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ABSTRACT

People aged 65 and over, and particularly the "old old," i.e., 75 and over, are the fastest growing age group in the United States. This group numbers 25 million in 1980, 11% of the population, with women outnumbering men by 5 million. Although a quarter of the federal budget goes to their support, poor coordination among federal programs for the elderly means that only three percent benefit from government housing programs and 33% remain ill-housed. Nearly 25% live near or below the poverty level. The impact of inflation on fixed retirement incomes may discourage early retirement and force many older adults back to work. Although elderly Americans are healthier than ever before, many over age 75 need long-term health care. Financial coverage for home care is extremely limited under current Medicare and Medicaid regulations. Future shifts in policy for the elderly may include increasing the eligible age for retirement benefits, encouraging greater pre-retirement savings, and shoring up the support network of family and friends. Growing problems of the elderly in less developed nations will be the focus of the United Nations World Assembly on the Aging in 1982. (Author/NRB)

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America's Elderly in the 1980s

By Beth J. Soldo

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Abstract—Thanks to high pre-World War I fertility and a life expectancy increase from 47 years in 1900 to 73 in 1978, people aged 65 and over, and particularly the "old old" 75 and over, are the fastest growing group in U.S. society. They number 25 million in 1980, 11 percent of the population, with women outnumbering men by 5 million. A quarter of the federal budget, $155 billion in 1980, now goes to their support. But poor coordination among the 135 to 200 federal programs serving the elderly means many go in need. Only 3 percent benefit from government housing programs and a third remain ill housed. Close to a quarter live near or below the poverty level while Social Security funding of retirement benefits is in trouble and much more could lie ahead when the baby boom generation swells this age group to 45 million in 2020. Currently, the impact of inflation on fixed retirement incomes may be reversing the trend toward early retirement and forcing many elderly back to work. Although elderly Americans are healthier than ever before, many of those 75 and over need long-term health care. Financial coverage for the home care which they and their families prefer is extremely limited under current Medicare and Medicaid regulations. Future shifts in policy on the elderly may include increasing the eligible age for retirement benefits even beyond 65, encouraging greater personal pre-retirement savings, and shoring up the "informal support network" of family, friends, etc., which already provides most of the elderly's support. The national programs for the elderly characteristic of all aging developed nations are necessarily limited in developing countries where proportions of people 65 and over are still small but their numbers will double to 229 million in 2000, 58 percent of a then world total of 396 million elderly. Growing problems of the elderly in less developed nations will be the focus of the United Nations World Assembly on the Aging in 1982.

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By Beth J. Soldo

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The author's grandparents celebrate their 50th wedding anniversary. People aged 65 and over, who number 25 million and make up 11 percent of the total population in 1980, are the fastest growing group in U.S. society.

America's Elderly in the 1980s

By **Beth J. Soldo**
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Dr. Soldo acknowledges the research and editing assistance provided by Joan Broyles, Center for Population Research, Georgetown University. Jean van der Tak, PRB Director of Publications, also was an energetic editor and reader of the Bulletin *manuscript. Preparation of this* Bulletin *was supported partially through funds provided by the ARCO Foundation to the Center for Population Research and this support is gratefully acknowledged.*

Every day in the United States some 5,000 persons celebrate their 65th birthday and about 3,400 persons that age and older die. The new entrants into the older population are quite different from those already 65 years of age and older and "worlds apart from those already centenarians who were born shortly after the Civil War."[1] They differ not only in age but also in their life histories, experiences, attitudes, and preferences. Because of demographic changes and variations from generation to generation, the older population is being constantly renewed, expanded, and transformed. America's elderly in the 1980s will differ from the elderly of both 1960 and 2000.

There are 25 million persons aged 65 and older in the U.S. today who make up 11 percent of the total population, up from 9 million and 7 percent of the population just 40 years ago. With declining birth rates and a progressively aging population, people 65 and over, and particularly those 75 and over, are the fastest growing group in our society. The proportion of elderly is expected to go up to 12 percent in 2000 and 16 percent in 2020 when there will be 45 million of them in a population of 290 million. This is partly the result of low birth rates and partly because more people are living longer—life expectancy for U.S. men is now almost 70 and over 77 for women compared to 58 and 62 as recently as 1930. Also the baby boom generation is growing up. Much of the student unrest and high unemployment and crime rates of the late 1960s and 1970s and current inflated housing demands has been caused by a greatly disproportionate number of young people in the population. When the same imbalance develops in the older age groups after 2010 there are bound to be repercussions in a different form.

Already "gray power" has become a household word; a septuagenerian takes over the presidency in January 1981 and grandmothers are beginning to displace teenagers in TV commercials.

A quarter of the federal budget now goes to support America's elderly—$155 billion in fiscal year 1980. But only 3 percent of the elderly benefit from government housing programs and a third remain ill housed. Close to a quarter live near or below the poverty level while Social Security funding of retirement benefits is already in trouble and much more could lie ahead when the baby boom generation begins to retire. And although elderly Americans are healthier than ever before, many of those over 75 need long-term health care. To receive financial support of such care, it is easier to enter a nursing home than to stay at home as most of the elderly would prefer.

To set these problems in context, this *Bulletin* opens with sketches of the demography and health status of today's elderly, followed by descriptions of factors such as education, income and housing that shape their "quality of life." Current major federal and private programs for the elderly are then outlined and evaluated, with particular emphasis on the problems of today's systems of Social Security retirement funding and public health care for the elderly. The conclusion takes a look at the situation of the elderly in developing countries and other Western aging societies.

The Clock Starts Ticking

Defining the "elderly"

The very nature of the human aging process makes it difficult to pinpoint the boundary line between middle age and old age. "Old age" does not begin, as if by magic, on some predetermined birthday. The clock starts ticking the moment we are born and each of us is constantly and continually aging. Changes from one day to another may be imperceptible, but physical, social, and economic changes nonetheless accumulate with the passage of time. Often it is only the outward evidence of these changes that is postponed to old age. Postmortem examinations of young men in their early 20s, for example, reveal signs of hardening of the arteries, a disease associated by many only with old age. Thus, each of us, young and old alike, participates in the inevitable and irreversible process of human aging.

Although human aging is inevitable, there is no fixed "aging" timetable to which we all adhere. Because of the interaction between heredity and environment (which includes life styles), no two individuals age in exactly the same way. Of course, some individuals lose their immunity to disease in old age and some become senile, but severe physical and mental debility are not our destiny.[2] Even at the extremes of old age, individuals differ physiologically and functionally. Variations in the rate and timing of major aging events make for differences between people in any age group and the elderly are no exception. If anything, the accumulation of life experiences accentuates rather than diminishes differences between one older person and another.

Human aging is also a multidimensional process involving all the biological, social, and cognitive systems that define life itself. Aging refers not only to the "biological capacity for survival," but also to the "psychological capacity for adaptation and the sociological capacity for the fulfillment of social roles."[3]

Not all systems, however, age at the same pace. In most individuals, the physical senses wane long before there is any noticeable loss in mental function. This makes for differences within individuals themselves as can be graphically demonstrated to someone defeated

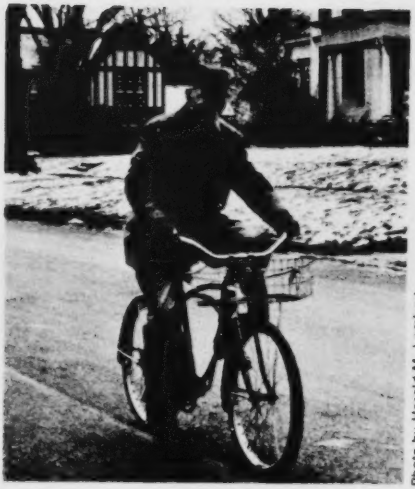


Photo by Harold M. Lambert

by an "old" opponent whose gray hair, receding hairline, and wrinkled skin belie competitive skill on the tennis court.

Because of differences between and within individuals, chronological age is only loosely correlated with functional age—a person's capacity for work, intellectual accomplishment, and self-maintenance. Many practitioners and researchers argue that functional age is a much better indicator of old age than simply the number of years elapsed since birth. But even if gerontologists could agree on a common standard, assessing functional age in a large population would be a time-consuming and expensive task that would have to be updated on a regular basis. Despite its ambiguities, chronological age is a standard that is easy to interpret and widely used.

Any definition of "old age" based on chronological age is mainly one of choice, bound, in large measure, by history and custom. In Caesar's time, the average length of life was about 25 years and anyone surviving beyond their 40th birthday was surely described as "old." What we today define as the prime of life was for the Romans the extreme of old age. As the odds of surviving beyond young adulthood and through middle age improved, the chronological benchmark of "old age" also shifted upward. In the United States today, the "perks" of senior citizen status are generally made available to those who have celebrated their 65th birthday. At age 65, an individual is eligible for a full retirement benefit from Social Security, Medicare coverage, and such advantages as reduced air and bus fares.

The official use of age 65 to identify the elderly traces back to the original Social Security Act of 1935. More recently, slightly younger definitions of old age have been used in federal and state legislation. The boundary line is now 55 for employment services geared to the "elderly," 60 for nutrition services, and 62 for reduced Social Security retirement benefits. It is ironic that as legislative decisions about old age reach down even into the sixth decade of life (the 50s), the onset of conditions that stereotype "old age" (poor physical health, dependency, and cognitive impairments) are being postponed to the eighth and even ninth decades of life—the 70s and 80s.

In this *Bulletin*, the elderly are defined as people 65 years of age and over, a definition that is warranted for the practical reason that more data are available that way, but adopted with this strong warning. The elderly are an extremely diverse group, spanning a 30- to 35-year age range. If we were to treat together such a large age group earlier in the life cycle—people 20 to 55 years of age, for example—few would be convinced that the behavior and attitudes of a college-age student are enough like those of a middle-age worker to justify the use of such a broad age category. It is also unreasonable to anticipate homogeneity from the elderly population or to present data in such a way as to suggest homogeneity. At a minimum, the "young old" should be

distinguished from the "old old," with age 75 used as the dividing line.[4] This age distinction is used whenever possible in this *Bulletin*.

Demography of Today's Elderly

At any point in time, the older population can be identified in terms of specific birth cohorts* that straddle the older age groups. Cohorts born in 1915 and earlier define the elderly population by 1980. By 1990, people born from 1916 to 1925 will be numbered among the elderly.

Each cohort arrives at the threshold of old age with a unique life history reflecting the imprint of previous life cycle stages intersecting with differing social, economic, and political circumstances. All of today's elderly survived World War I, the flu panepidemic of 1919-20, the Great Depression of the 1930s, and World War II. But it is not simply exposure to these major events that shaped the life history of those who are now elderly; it is also how old they were when these events happened. Cohorts who experienced the Depression during their childbearing years, for example, have the lowest *completed* fertility of any observed so far in this century. In old age the survivors of these cohorts (those born roughly between 1900 and 1910) have smaller families on average to rely on than those born only ten to 20 years earlier or later. Such unique life histories shape the old age experience of the cohorts now 65 years of age and older and help to differentiate them from those who will be old 10, 20, or 40 years from now.

The following subsections outline the demographic characteristics of today's elderly. This sets the stage for considering the health and socioeconomic changes associated with old age and the responses and adaptations that the older cohorts of 1980 and organizations that deal with them are making to these changes.

Numbers

Throughout this century, the size of the U.S. elderly population has increased steadily and dramatically (Table 1). In 1900 only 3 million people in a total population of 76 million were 65 years of age and over. By the mid-point in the century, older men and women had more than quadrupled to slightly over 12 million, and by 1980 the numbers more than doubled again to 25 million. This eightfold increase in the last 80 years far outpaced the near tripling of the total U.S. population to 222 million (or perhaps 226 million) during the same period. All of the basic demographic processes—fertility, mortality, and migration—contributed, but unequally, to the rapid growth in the number of older Americans.

The maximum size of the older population at any point in time is determined by the number of births 65 to 75 years earlier. The large number of elderly today is due most of all to the high fertility of the late 19th and early 20th centuries.

Second in importance in explaining the extraordinary expansion of the elderly population is mortality decline. Between 1900 and 1954, the risk of infant and childhood mortality dropped rapidly due largely to improved sanitation and the introduction of antibiotics and vaccines for such diseases as polio.[5] All cohorts that have aged during this century have benefited from the reduced chances of death from infectious disease and more of each cohort have thus lived to reach age 65. Only four out of ten of those born in 1900 could expect to survive to age 65; today more than seven out of ten newborns are expected to attain this milestone.

The size of the older population in the later part of this century also bears the unique historical imprint of the large

* A cohort consists of all the people born within a stated short period, e.g., a year or five or ten years.

Table 1. Total U.S. Population and Population 65 and Over with Decennial Increase: 1900-1980

Year	Total U.S. population		Population 65 and over	
	Number (in 1,000s)	Percent increase from preceding decade	Number (in 1,000s)	Percent increase from preceding decade
1900	75,994	20.7	3,099	
1910	91,972	21.0	3,986	28.6
1920	105,711	14.9	4,929	23.7
1930	122,755	16.1	6,705	36.0
1940	131,669	7.2	9,031	34.7
1950	150,697	14.5	12,362	37.3
1970[a]	203,235	13.3	20,156	20.4
1980[b]	221,700	9.1	24,830	23.2

Sources: U.S. Bureau of the Census, *Historical Statistics of the United States: Colonial Times to 1970*; and *Current Population Reports*, Series P-25, No. 704, "Projections of the Population of the United States: 1977-2050."

[a]First year for which figures include Alaska and Hawaii.

[b]These Census Bureau estimates for 1980 were published in 1977 and were the latest officially available at the time this *Bulletin* went to press in November 1980. Unofficially, the Census Bureau has announced that the U.S. population may have totaled as high as 226 million on Census Day, April 1, 1980.

pre-World War I immigration waves. These immigrants were mostly young adults from Southern European countries who swelled the numbers in their respective, already large, native-born age groups. This immigration effect has largely played itself out, however, as the surviving immigrants are now in their late 80s and early 90s.

Dramatic swings in the fertility rate during the mid-part of this century will largely determine the size of tomorrow's older population. The ranks of the elderly will continue to grow at least through 2030 but at varying rates. The U.S. Bureau of the Census projects that the elderly population will go up by 15 percent during the 1980s to reach nearly 30 million in 1990—a smaller gain than the 23 percent of the 1970s. Between 1990 and 2010 the effect of the small Depression-era cohorts will slow the growth of the older population to a modest 7 percent in the 1990s and 10 percent in the first decade of the 21st century. This translates into a likely 32 million elderly persons in 2000 and 35 million in 2010. After 2010 the aging of the post-World War II "baby boom" generation will set off a "senior boom," resulting in 45 million elderly by 2020 and 55 million in 2030—a 57 percent increase in two decades. Much of the current concern over an aging society simply anticipates this abrupt surge in the number of older persons beginning some 35 years from now. After 2030 the growth of the older population will probably fall sharply again as the small cohorts born during the later 1960s and the 1970s cross the threshold into old age.

Barring any sudden fall in deaths from chronic disease, projections through to 2030 are likely to be reasonably accurate as these future elderly are already alive today. Anticipating the size of the older population through this period mainly involves projecting the future course of mortality, the most stable of the demographic processes, although future unpredictable trends in immigration also play a small role. Projections much beyond 2030 also re-

quire forecasting trends in the birth rate, a considerably more difficult task for demographers.

Proportion of total population

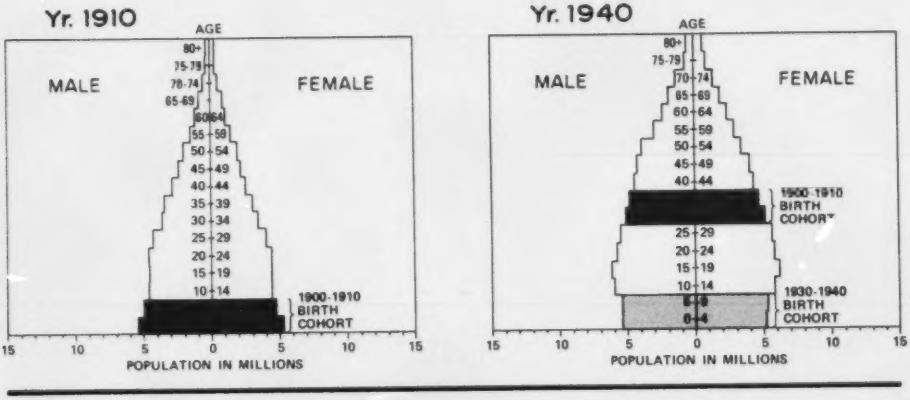
The proportion of persons aged 65 years and over in the U.S. population has also mounted during the last 80 years (see Table 2). The "aging of the population" refers to this increase in the relative number of elderly rather than the spectacular gain in absolute numbers.

In 1900 the U.S. was a "youthful" country, demographically speaking, with only 4 percent of the population elderly.[6] Forty years later the elderly had tripled in number, but still accounted for only 7 percent of the total population. By 1950, with 8.2 percent of its population aged 65 and over, the U.S. had taken on a "mature" age structure. In 1980, one in nine Americans (11.2 percent) are 65 and over and the U.S. is now considered an "aged" population. However, the U.S. is far from being the "oldest" country in the world today. Most Western European nations have older age structures and in at least four countries (Austria, East Germany, West Germany, and Sweden), the proportion of elderly already exceeds 15 percent.

Increases in the proportion of elderly also help boost the median age of a population. In the U.S. today, a person is demographically "over the hill" after age 30. 1980 marks the second time in this century when half of the population is 30 years of age or older (Table 2).

It is important to realize that changes in the proportion of the elderly (unlike changes in numbers) are affected by variations in the numbers of people in other age categories. Basically, an increase in the proportion of population 65 years and over is due more to declining fertility than to lower death rates. A fall in fertility like that of the last 15 to 20 years in the U.S. reduces the proportion of young persons and thus increases the proportion of adults and older persons in the population. Declining mortality, on the other hand, usually increases the relative number of children and adolescents, although this is no longer true in

Figure 1. Age Structure of the U.S. Population: 1910, 1940, 1960, 1980



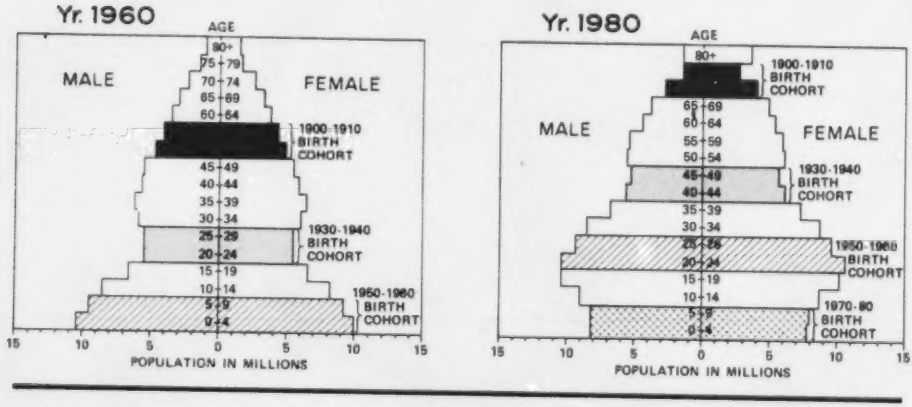
Sources: 1910, 1940: U.S. Bureau of the Census, *1970 Census of Population: United States Summary*, General Population Characteristics, PC(1)-B1 (Washington, D.C.: U.S. Government Printing Office, 1972); 1960, 1980: Leon F. Bouvier, "Amer-

Table 2. Percent of Population 65 and Over and Median Age of Total U.S. Population, 1900-1980, and Projections Under Varying Fertility Assumptions, 1990-2040

Year	% of total population aged 65 and over	Median age of total population
	Estimates	
1900	4.1	22.9
1910	4.3	24.1
1920	4.7	25.3
1930	5.5	26.5
1940	6.9	29.0
1950	8.2	30.2
1960	9.3	29.5
1970	9.9	28.1
1980	11.2	30.2
	Projections[a]	
1990	12.1 (11.7 – 12.6)	32.8 (31.4 – 33.7)
2000	12.2 (11.3 – 12.9)	35.5 (32.5 – 37.3)
2010	12.7 (11.1 – 13.9)	36.6 (31.1 – 40.2)
2020	15.5 (12.7 – 17.8)	37.0 (31.4 – 41.7)
2030	18.3 (14.0 – 22.1)	38.0 (31.2 – 43.2)
2040	17.8 (12.5 – 22.8)	37.8 (30.7 – 43.9)

Sources: U.S. Bureau of the Census, *Historical Statistics of the United States, Colonial Times to 1970;* and *Current Population Reports*, Series P-25, No. 704, "Projections of the Population of the United States: 1977-2050."

[a]Base data of projections are for July 1, 1978. Main projection assumes replacement-level fertility (2.1 children per woman). Range in parentheses is that implied by above-replacement-level fertility (2.7 children per woman) and below-replacement-level fertility (1.7 children per woman).



ica's Baby Boom Generation: The Fateful Bulge," *Population Bulletin*, Vol. 35, No. 1 (Washington, D.C.: Population Reference Bureau, 1980) Figure 4.

the U.S. Until recently in the U.S. and other developed countries and still today in the less developed world, decreases in death rates have been linked to reduced mortality from infectious disease which tends to benefit the young more than the old.

The aging of the U.S. population is illustrated in Figure 1. At the beginning of this century, both fertility and mortality were relatively high. As a result, the population pyramid, which shows the percentage distribution of the population by age, was fairly broad at the base and the apex was narrow in 1910. By 1940 fertility had declined but potential reductions in the relative size of the younger age groups were offset by improved survivorship for those age groups. Fertility remained low during the 1940s and the relative number of elderly increased 37 percent. The baby boom of the 1950s, however, significantly broadened the base of the population pyramid for 1960 and the aging of the U.S. population was slowed. The small size of the cohorts born during the last 10 to 15 years, coupled with the aging of the large birth cohort of 1900-1910, has again stimulated rapid aging of the U.S. population as seen in the widened apex of the pyramid for 1980.

Figure 1 also shows the way in which specific birth cohorts wash upward through the age structure and variously alter the age distribution of the population as they do so. The baby boom fertility burst temporarily stayed the aging of the population in the 1950s, swamped elementary and secondary schools during the 1950s and 1960s, and flooded the job market during the 1970s. This birth cohort of the 1950s is so large that the proportion of elderly between 2010 and 2020 will increase regardless of whether fertility remains at its current low level of about 1.8 children per woman or takes an unexpected turn upward toward an average of 3 children.

If fertility increases slightly to replacement level (2.1 children per woman), the Census Bureau projects about 12 percent elderly in 2000, nearly 16 percent in 2020, and 18 percent in 2030 (Table 2). Below-replacement fertility (1.7 children per woman) will result in nearly 13 percent of the population in the older age groups in 2000, 18 percent in 2020, and 22 percent in 2030. Above-replacement fertility (2.7 children per woman) would slow the aging of the population slightly, producing a concentration of 11.3 percent elderly in 2000, about the same as now in 1980, and 13 percent in 2020 and 14 percent in 2030. Regardless of the fertility assumption used, the U.S. population will continue to be counted among the demographically old nations of the world.

It is important to note that if current below-replacement-level fertility continues (which appears likely), only substantial mortality reductions, concentrated in the older ages, would push the proportion of elderly beyond 22 percent.[7] The one-third proportion of elderly predicted by some writers assumes almost immediate and huge (20- to 30-year) extensions in life expectancy. Such a large decrease in mortality is extremely unlikely. The causes of the chronic diseases which bring on most deaths among the elderly are complex and interwoven with the basic physiology of aging in such a way that they will probably not yield to a single, cause-specific "cure."

Differences within the older population

Age. The elderly population is itself aging so dramatically that Dr. Harold Sheppard, counselor on aging to President Carter, describes it as an "implosion," literally an inward explosion. While the elderly population as a whole increased by 23 percent from 1970 to 1980, the number of elderly 85 years of age and over increased by 60 percent. Over the next 20 years, the number of those 65 and over is expected to

Table 3. Percent Distribution of Population 65 and Over, by Age: 1950-2020

Age	1950	1970	1976	Projections 1980	2000	2020
65-59	40.7	35.0	36.1	34.9	28.9	35.4
70-74	27.8	27.2	25.8	27.3	25.9	26.9
75-79	17.4	19.2	17.7	17.3	20.1	16.8
80-84	9.3	11.5	11.9	11.3	13.3	10.2
85 and over	4.8	7.1	8.6	9.2	11.8	10.6
Total 65 and over	100.0	100.0	100.0	100.0	100.0	100.0

Sources: U.S. Bureau of the Census, *Current Population Reports*, Series P-25, Nos. 311, 519, 614, 643, and 704.

go up by 28 percent, but the number 75 and over is likely to increase by 53 percent and the number of extremely old (85 and over) by 64 percent. Of the 7 million increase in the size of the older population likely to occur between 1980 and 2000, almost three-fourths of it (5 million) will be concentrated in the group 75 years of age and over.

The differential growth of age groups within the older population is resulting in increasing proportions of those at the extremes of old age (see Table 3). In 1950, 32 percent of elderly persons were 75 years of age or over; in 2000, some 45 percent will probably be in that category, of which well over half will be 80 years or older. This change has important policy implications which are often overlooked. It is the "old old" (those 75 years of age and over) who generate the most intensive demand for health care services, particularly costly long-term care services. It is important to realize that both the size *and* the composition of the older age group determine the scope of problems associated with an aging society.

Sex. "The problems of old age in America are largely the problems of women," says Dr. Robert Butler, director of the National Institute on Aging.[6] Six out of every ten older Americans are women. In 1979 women 65 and over outnumbered their male contemporaries by nearly 5 million, or—put another way—for every 100 women aged 65 and over there were only 68 men (see Table 4). With increasing age, the excess of females becomes even more extreme; for the population 75 and over, there were only 56 men for every 100 women in 1979.

The sex imbalance in the older population reflects higher male mortality over the entire age range. This mortality differential also accounts for the faster growth of the older female population. Between 1950 and 1976, men 65 and over increased by less than two-thirds while the number of older women more than doubled. The excess of male mortality at the oldest ages has also left its mark on the age composition of the older male and female populations. Men 75 years of age and over account for one-third of the elderly male population but among women 65 and over, the "old old" (75 and over) make up slightly over 40 percent.

The preponderance of older females is a relatively recent phenomenon. As little as 50 years ago, the count of older men and women was equal. But after 1930 women began surviving longer than men as maternal mortality and deaths from infectious diseases dropped rapidly and chronic diseases became the leading causes of death (see "Death and Illness" following). By 1960 the ratio of older men per 100 elderly women had dropped to 83 (Table 4). The trend has been the same, if less pronounced, for blacks as it has

Table 4. Men 65 and Over per 100 Women 65 and Over, by Age and Race: 1960-2000

Age and race	1960	1979	Projections 1990	Projections 2000
Total 65 and over	82.6	68.4	67.3	66.6
65-69	87.8	80.1	80.5	82.4
70-74	85.3	72.9	72.9	74.6
75-84	77.4	60.4	59.6	59.9
85 and over	63.8	44.7	40.9	39.4
White				
65 and over	82.1	67.8	67.7	64.6
75 and over	74.3	55.2	58.4	51.9
Black				
65 and over	90.1	71.0	68.2	67.8
75 and over	87.6	62.2	62.6	57.3

Sources: U.S. Bureau of the Census, *Current Population Reports*, Series P-23, No. 59; Series P-25, Nos. 311, 519, 614, 704, and 870.

been for whites (71 black elderly men per 100 black women in 1979 as compared to 68 white men 65 and over for every 100 white women that age.)

The discrepancy between the numbers of elderly women and men is expected to widen as numbers increase rapidly among the "old old" where women especially outnumber men. That has significant policy implications because older women have quite different social and economic resources. Far more older women are widowed, live alone, and on less income than older men.

Race. Approximately 2 million blacks are 65 years of age and over. They represent only 7.9 percent of the total black population while white elderly account for 11.8 percent of the total white population. This difference in age structure is reflected in the median age of the two populations. In 1979 when half of the white population was age 30.9 or older, the median age for blacks was 6.3 years lower: 24.6. These differences result from the higher fertility of blacks, which increases the percentage of young people, and higher infant mortality, which results in lower proportions of blacks surviving through to old age.

Older blacks are "a minority within a minority" but one which is growing rapidly.[9] The Census Bureau projects 3 million blacks 65 and over for the year 2000 which, if borne out, would increase the older black population by 46 percent in the next two decades, 21 percentage points more than the older white population over that time span.

Geographic distribution

Elderly persons are more heavily concentrated in the Northeast and North Central regions than in the South and West. Among states, the proportion of elderly ranges from a high of 18.1 percent in Florida and 13.7 percent in Arkansas to 2.6 percent in Alaska and 7.7 percent in Utah and Hawaii (Table 5).

While the national population increased 23.5 percent from 1970 to 1979, the older population in several states grew considerably faster. The largest percentage increases occurred in states with large numbers of older in-migrants: Nevada (96.6 percent), Arizona (79.5 percent), Florida (62.7

percent), Hawaii (59.9 percent), and New Mexico (54.8 percent).

Like younger Americans, a majority of those 65 and over (63 percent in 1979) live in metropolitan areas. But the elderly are more likely than younger citizens to be found in the central cities of metropolitan areas and in rural areas, particularly small towns.

In many American cities, residential segregation has resulted in what Donald Cowgill calls "gray ghettos" in the older core areas.[10] This does not reflect intentional discrimination; rather, while their children have moved to the suburbs, the elderly have stayed behind. In 1973, for example, a third of people 60 and over had lived in their current home for 20 years or more. The tendency for middle-aged persons to "age in place" suggests that close-in suburbs may be the "gray ghettos" of tomorrow.[11]

Similar patterns of "inertia and attrition" also explain the over-concentration of older persons in small rural towns. Until recently rural areas were losing population to urban places. Most of these rural-to-urban migrants were young adults seeking educational and employment opportunities. Those left behind were their parents. The proportion of elderly in small rural towns is probably also swollen by older farmers who use nearby rural, but nonfarm, communities as their "retirement centers."[12]

Contrary to popular opinion, relatively few Americans move during their retirement years. Among the "noninstitutionalized" elderly, only 18 percent of those aged 65 to 74 and 16 percent of those 75 and over changed their place of residence between 1975 and 1979 as Table 6 shows, compared to 40 percent of the general population aged four and over. Most of these elderly movers stayed within the same county; only about a fifth went to a different state during these four years.

Although the "young old" are about as likely to move as the "old old," the two age groups generally move for different reasons. People aged 64 to 74 who move some distance tend to be attracted by recreational opportunities and better climates. People who migrate later in life are more likely to be relocating because of their health, perhaps returning to their original place of residence or moving in with or nearby adult children.[13]

The Sunbelt states of Florida, California, and Arizona attracted more than half of the elderly who migrated to

Table 5. States by Percent of Population 65 and Over: 1979

Percent of population 65 and over	States
18.1	Florida
13.7	Arkansas
13.1	Iowa, South, Dakota
13.0	Missouri, Nebraska
12.7	Pennsylvania, Kansas
12.5	Oklahoma
12.3	Maine, Massachusetts
12.1	North Dakota
12.0	New York, West Virginia
11.8	Wisconsin, Arizona
11.6	Minnesota, Oregon
11.5	New Jersey
11.4	Connecticut, Mississippi
11.3	Vermont
11.2	Kentucky, Tennessee, Alabama
11.1	New Hampshire, District of Columbia
10.9	Illinois
10.6	Ohio, Indiana, Montana, Washington
10.2	North Carolina, California
10.0	Idaho
9.7	Delaware, Texas
9.6	Michigan
9.5	Georgia
9.4	Louisiana
9.3	Virginia
9.2	Maryland, South Carolina
8.8	New Mexico
8.6	Colorado, Nevada
8.1	Wyoming
7.7	Utah, Hawaii
2.6	Alaska

Source: U.S. Bureau of the Census, *Current Population Reports*, Series P-25, No. 875, "Estimates of the Population of States, by Age: July 1, 1971 to 1979."

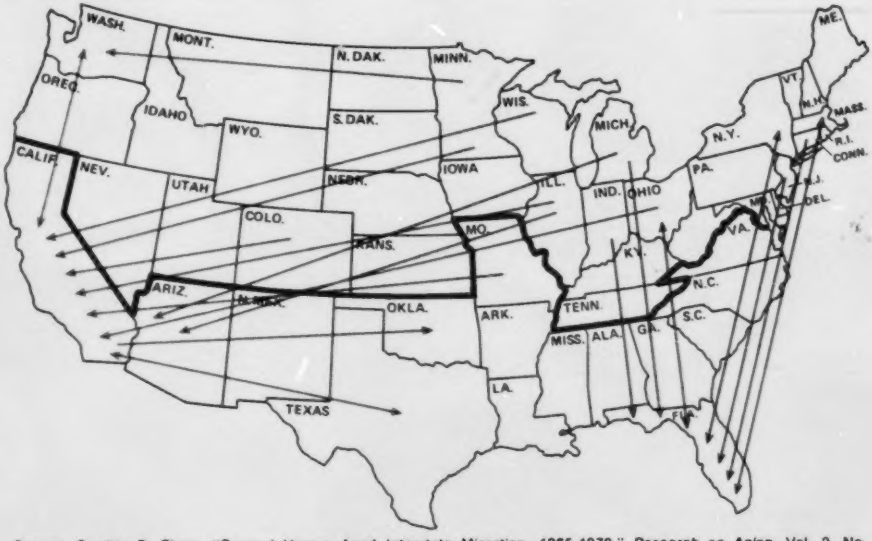
Table 6. Mobility of Population 65 and Over, by Age: 1975-1979

Mobility status and type of move	Age	
	64-74	75 and over
Total (in 1,000s)	14,767	8,408
Percent	100.0	100.0
Movers	18.1	15.9
Nonmovers	81.9	84.1
	Percent distribution by type of move[a]	
Total movers (in 1,000s)	2,614	1,315
Percent	100.0	100.0
Same county	55.7	58.2
Different county in same state	21.5	21.5
Different state, total	22.8	20.3
Contiguous state	6.4	6.1
Noncontiguous state	15.0	14.2

Source: U.S. Bureau of the Census, *Current Population Reports*, Series P-20, No. 353, "Georgraphic Mobility: March 1975 to March 1979," p. 15

[a]Excludes moves from abroad.

Figure 2. Main Migration Streams Between Noncontiguous States of Persons 65 and Over: 1965-1970



Source: Cynthia B. Flynn, "General Versus Aged Interstate Migration, 1965-1970," *Research on Aging*, Vol. 2, No. 2 (June 1980) p. 174.

distant states between 1965 and 1970. Florida alone was the destination for nearly a quarter of these movers. Figure 2 illustrates the overwhelming attraction of the Sunbelt for the elderly who moved between noncontiguous states during the latter half of the 1960s. The Mississippi River acts almost as the dividing line between the two major Sunbelt streams: for those living in the east, Florida is the major state of destination, while for those originating in the west, California is the primary receiving state. Secondary to these major migration streams are the South to North flows of the Snowbelt migrants who are more likely to be returning to their states of birth.[14]

Older persons migrating to the Sunbelt tend to be the younger and more affluent of the elderly population. In the short run, at least, they benefit rather than handicap their places of destination. Most quickly become homeowners and thus help broaden the tax base in their new communities and, since most are retirees, they exert little pressure on the local job market. If they stay and as they age, however, Sunbelt migrants may increase the long-range demand for old-age services in the states where they settle. The effect on the states they come from is more immediate. Snowbelt states lose more affluent elderly through out-migration than they gain and the elderly left behind are older and their financial resources more limited. Thus as a result of out-migration, Snowbelt states usually experience a relative increase in demand for income maintenance and social or health assistance programs.[15]

Death and Illness

Changing patterns in mortality underlie many of the demographic trends described above and these in turn have changed the typical illnesses of the elderly. Both, of course, affect what is a major preoccupation of the elderly and those concerned with them—their health.

Changes in mortality

The nation's crude death rate has declined during the course of this century from 17 per 1,000 population to less than 9 per 1,000 in recent years. This progress has favored younger people more than the old as illustrated by the shifts in life expectancy shown in Table 7.

A child born at the turn of the century could expect to live to age 47.3, on the average; by 1978 the average was up to 73.3—a gain of 26 years. A person aged 65, on the other hand, could look forward to another 11.9 years in 1900 and 16.1 in 1978—a gain of only 4.2 years. Most of the increase in life expectancy at birth occurred before 1950. The rate of improvement slowed for the next two decades but picked up again between 1970 and 1978 when the gain was 2.4 years—amost as much of an improvement as there was between 1950 and 1970.

At all ages, men have shorter life expectancies than women and at all but the extremes of old age, blacks have fewer years ahead than whites. The average white woman of 65 in 1978 could expect to live to age 83.4—4.4 years longer than either a white or nonwhite man and 2.3 years more than a nonwhite woman. Over time, for both whites and nonwhites, male-female differences in life expectancy have widened while white-nonwhite differences, regardless of sex, have narrowed.

Improvements in life expectancy over the past 80 years and the different effects of these improvements by age, sex and race are related to changes in the structure of mortality. The highlights of these changes are: a dramatic fall in deaths from infectious diseases and tuberculosis, a modest decline in diseases of early infancy, and marked increases in death rates for heart disease and cancer. The leading causes of death have now shifted from communicable to chronic diseases and, today, heart disease, cancer, and stroke account for two-thirds of all deaths. In

Table 7. Life Expectancy at Birth and at Age 65, by Race and Sex: 1900, 1950, 1978

Age, sex, and race	1900[a]	1950	1978[b]
		Life expectancy at birth	
Total	47.3	68.2	73.3
Men	46.3	65.6	69.5
Women	48.3	71.1	77.2
White	47.6	69.1	74.0
Men	46.6	66.5	70.2
Women	48.7	72.2	77.8
Nonwhite	33.0	60.8	69.2
Men	32.5	59.1	65.0
Women	33.5	62.9	73.6
		Life expectancy at age 65	
Total	11.9	13.9	16.1
Men	11.5	12.8	14.1
Women	12.2	15.0	18.0
White	—	—	16.4
Men	11.5	12.8	14.0
Women	12.2	15.1	18.4
Nonwhite	—	—	16.1
Men	10.4	12.5	14.0
Women	11.4	14.5	16.1

Sources: National Center for Health Statistics, *Health, United States: 1979* (Washington, D.C.: U.S. Government Printing Office, 1980) p. 138, and "Final Mortality Statistics, 1978," *Monthly Vital Statistics Report*, Vol. 29, No. 6, Supplement 2 (September 1980).

[a] Death registration area only.

[b] Excludes deaths of U.S. nonresidents.

1900 this particular cluster of diseases was responsible for only about one out of every eight deaths in the U.S.

Young children have benefited most from the tradeoff between the decreased risk of dying from infectious disease and consequent increased risk of death from a chronic disease. These changes also favor women more than men. Men are more likely to die from the now prevalent chronic diseases, particularly from heart disease and stroke.

The risk of death is also higher for nonwhites than whites with some of these "degenerative" diseases—hypertension, for example. Death from a communicable disease is also still more common among nonwhites than whites and this, combined with the greater prevalence of chronic diseases where their death rates are higher, results in an overall, age-adjusted death rate for nonwhites that was 1.4 times that for the white population in 1978. However, at the extremes of old age—80 and over—nonwhites (who are mostly blacks) have lower death rates than whites, although some of this may be because elderly blacks sometimes claim to be older than they actually are.

As more and more Americans are surviving through childhood, adolescence, young adulthood, and middle age, death is becoming increasingly an event of old age. Of the nearly 2 million deaths recorded in the U.S. in 1978, two-thirds occurred to the elderly. About 45 percent of these deaths were due to heart disease and three-quarters were due to the three major killers combined

—heart disease, cancer, and stroke.

Although heart disease was still the number one cause of death among the elderly in 1977, death rates for both heart disease and stroke have been declining over the past decade. The 1977 heart disease death rate for people 65 and over was only 87 percent of the 1970 rate and 83 percent of the 1960 rate, with the decline being greatest for white males and least for black females. At the same time the aged death rate for cancer has increased—by 7 percent for all elderly persons between 1970 and 1977 and 10 percent for white males and black females 65 and over.

Illness

Old age in itself is not a disease, but even the specialists sometimes have trouble distinguishing physical changes in a person which come with normal aging and cannot be reversed from conditions due to diseases related to these normal changes which *are* treatable.[16] Normal aging involves a general decline in the functioning of all the body's systems. Muscle strength gradually diminishes, bones become more brittle, response time slows, and the senses dull. The urinary, kidney, renal, and cardiovascular systems also deteriorate with the passage of time. With all these changes, it is hardly surprising that the elderly are more susceptible to chronic diseases. It is ironic, however, that "by successfully navigating through the various acute and infectious diseases of childhood and youth and by surviving or avoiding any number of accidents, individuals gradually incur an increasing risk of developing diverse chronic conditions."[17]

Only 14 percent of the noninstitutionalized elderly can claim to be free of chronic illnesses. The most frequently reported chronic afflictions are arthritis, heart problems, hypertension, and diabetes. Except for diabetes, each of these diseases affects 20 percent or more of the elderly. Statistician Mary Grace Kovar notes that "prevalence rates for all of these conditions are higher in non-metropolitan than in metropolitan areas and higher in the South than in other regions."[18] And because women live longer than men, most chronic conditions are more prevalent among older females.

For the most part the elderly adapt well to chronic illness and do not see themselves as grossly impaired. Only about four in ten older noninstitutionalized adults with a chronic condition reported any limitation in activity as a result of the disease in 1977. About 5 percent were housebound but only slightly over 1 percent were bedridden. Some 13 percent had trouble getting around: 7 percent said they needed help from another person or a mechanical aid and 6 percent were mobile alone with some difficulty.

Seven in ten elderly in the community also evaluate their health as good or excellent. If the 5 percent of the elderly population in hospitals and nursing homes are counted as being in poor health, then only about 14 percent of all elderly would be so categorized. Members of minority groups and low-income elderly are more likely to report their health as poor. As Table 8 shows, the percentages of elderly reporting restricted activity and poor health increase with age and are generally higher for men than for women.

The mental health of elderly Americans is far better than depicted by popular stereotypes. Only 4 to 6 percent—and a fifth of those 80 and over—suffer from "organic brain syndrome"—progressive deterioration of mental faculties.[19] This is not an inevitable consequence of surviving the proverbial three score years and ten but refers to a specific set of diseases, some of which are treatable although the most common, Alzheimer's disease, is not. It should not be mislabeled as senility, the popular catchall expression for severe mental debility, temporary or long term, which can afflict the aged. The elderly are more likely than younger people to

Table 8. Self-Reported Health Status of the Noninstitutionalized Elderly, by Age and Sex: 1976

Age	Total	Men	Women
	Percent unable to carry on major activity		
65 and over	17.6	29.9	9.0
65-74	14.7	26.6	5.5
75 and over	22.7	36.4	14.5
	Percent reporting poor health		
65 and over	9.0	9.3	8.8
65-74	8.5	9.2	8.1
75 and over	9.9	9.7	10.0

Source: Mary Grace Kovar, "Statement, May 24, 1978," in *Consequences of Changing U.S. Population: Demographics of Aging*, Joint Hearings before the Select Committees on Population and Aging, U.S. House of Representatives (Washington, D.C.: U.S. Government Printing Office, 1978) p. 140.

become temporarily confused, but often this merely goes along with an infection and high fever.

The most common emotional disorders among the elderly are chronic anxiety and depression. The suicide rate of the elderly is the highest of any age group, perhaps due to the sense of "role" loss that can come with retirement.

Psychologically, however, older people perceive themselves as better off than younger people might think. Over half of the over-60s interviewed in a recent national survey reported themselves as "highly optimistic" and close to 30 percent were classified as "enjoyers who manage to master all the difficulties that come with aging."[20] About half, however, were classified as "survivors"—merely coping with the problems of old age—and 20 percent were "casualties"—crushed by the difficulties of old age. Most of the survivors and casualties were women. The survey found that happiness and optimism for the elderly, as for younger people, are linked to good health, economic security, and a satisfying relationship with an equally healthy spouse.

Use of health care resources

Older people naturally require more medical help than the general public, especially after age 75. In 1979, noninstitutionalized elderly people reported an average of 6.3 physician visits per year in contrast to 4.7 for the general population. About one in four of these visits was for treatment of heart and circulation problems.[21] Although the elderly comprise only 11 percent of the total population, they occupy at least 30 percent of hospital beds reserved for acutely ill patients and stay longer than the middle-aged, and they receive 25 percent of all prescriptions. The majority of institutional long-term care services are also consumed by the elderly. Persons 65 years of age and over accounted for two-thirds of the total institutionalized population and 84 percent of all nursing home residents in 1976. Overall, however, only 5 percent of elderly people are institutionalized at any one time.

Quality of Life

Next to health, economic and social resources make the most difference in the quality of daily life for the elderly. Compared to younger people, the elderly have lower incomes, spend relatively more of their income on food, housing, and health care, and, particularly for older women, are more likely to be widowed and living alone. On the plus side of the equation, a majority of older adults are homeowners, often

owning their homes mortgage-free, and are integrated into a strong and nearby family support network.

Education

Because educational levels have increased over time, older people are not as well educated as those that follow them. By 1978 half of the population under 65 had at least a high school education but only a third of those 65 and over had graduated from high school. About one-tenth of today's elderly are "functionally illiterate," having had less than five years of schooling. As the better educated come along, the educational attainment of the elderly will go up. Already, between just 1970 and 1978, the median number of school years completed by the 65-and-over age group increased from 6.2 to 7.1 years.

Although most elderly people are no longer concerned with converting their educational attainment into wages, comparatively low levels of education do handicap the elderly of today. Poorly educated older adults often have trouble finding out about service and benefit programs for the elderly and, once they do, find it difficult and frustrating to deal with the paperwork and bureaucratic hurdles built into many such programs.

Photo by Harold M. Lambert

Employment

Not all people retire at age 65; many do so in their late 50s and early 60s and a few continue working into their 70s. Among men in 1978, for example, labor force participation rates dropped from 83 percent for those aged 55-59 to 63 percent among those 60-64 years of age to 21 percent for the 65 and overs. A majority of the 2.0 million older men and 1.1 million older women still in the labor force after age 65 in 1978 were working in low-paying, white-collar, and service jobs.

Styles of retirement also vary. For some older adults, retirement is a specific event, celebrated by gifts and parties on their last day of work; for others, it is a gradual process marked by shifts from full-time work to reduced hours per week or fewer weeks per year and finally to full retirement. A survey reported in 1977 which followed people through the retirement process suggests that gradual retirement is not the norm; only about one in ten withdrew gradually from the labor force.[22] It is difficult to determine whether most workers retire abruptly by choice or because part-time jobs for older people are scarce. In 1977, however, a quarter of the men and half of the women still in the nonagricultural labor force were working part time by preference.[23]

For an unknown proportion of elderly, retirement is neither a specific event nor a gradual voluntary reduction in work involvement. "Retirement" for the "discouraged older worker" is simply a more socially acceptable description of a long period of unemployment. Official unemployment rates for those 65 and

over are low (3.8 percent for whites, 7.1 percent for black men, and 4.8 percent for black women in 1978), but these statistics do not include older workers who simply stop looking for a job.

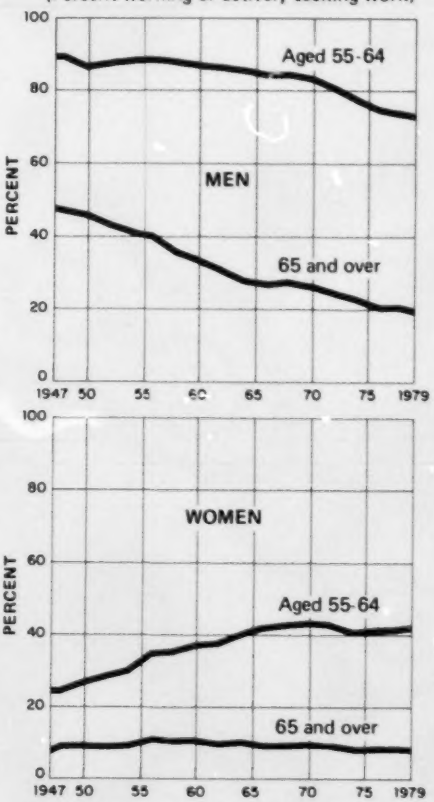
Older adults (55 and over) who do go on searching for a job average much longer stretches of unemployment than younger workers. The older job-seeking adult may also be handicapped by outdated job skills and less education than his or her younger competitor. And, although declared illegal since 1968, the older job applicant can be a victim of discrimination based on age, or "ageism." In fiscal year 1977, complaints alleging age discrimination were filed against 5,054 establishments.[24]

Early retirement has caught on rapidly with U.S. men over the past two decades as seen in the labor force participation rate for men aged 55 to 64 shown in Figure 3 which dropped from 90 percent in 1947 to 73 percent in 1979. Increased Social Security benefits and greater coverage by private pension plans undoubtedly fueled this trend. In 1976, for example, three-fourths of retirement claims filed with the Social Security Administration were for the reduced benefits available to those who retire between ages 62 and 64 compared to just half of the claims filed only 15 years earlier.[25]

Among women aged 55 to 64, the trend was just the opposite—a near doubling of those in the labor force from 24 percent in 1947 to 42 percent in 1979. The trends also diverged sharply between men and women aged 65 and over in this time period—a precipitous drop from 48 percent to just 20 percent in the labor force for men and the same 8 percent rate in 1979 as in 1947 for women (Figure 3).

Since January 1979 under the Amendments to the Age Discrimination in Employment Act, the age when most workers can be compelled to retire has been raised from 65 to 70. Opponents to the legislation argued that, if retirees

Figure 3. Labor Force Participation of Men and Women Aged 55-64 and 65 and Over: 1947-1979



Sources: Bureau of Labor Statistics, *Handbook of Labor Statistics: 1978;* and U.S. Bureau of the Census, *Current Population Reports*, Series P-20, Nos. 336 and 350.

flocked back to work or the trend toward early retirement were reversed, general unemployment rates would soar and young people would be stymied in their chances for promotion. So far there is little evidence that the new legislation is luring retirees back to work in substantial numbers or prompting many to abandon plans to retire early. Very re-

cent press reports and some surveys do suggest an increase in the number of older people who are postponing retirement or returning to work—or trying to.[26] The main reason, however, is the havoc which inflation can play with low, fixed retirement incomes. The return to work is encouraged by regulations which now allow retirees over 65 to earn up to $5,000 annually without forfeiting any of their Social Security retirement benefits. The ceiling will be raised another $500 each year through 1982 and then increase automatically in proportion to average wages nationally.

Numerous research studies indicate that both retirees and older workers have positive attitudes about retirement,[27] although one recent study suggests that the relative number of those with favorable opinions has declined since the late 1960s.[28] Very few retirees report a sense of job deprivation per se. The most frequently voiced complaint about retirement, particularly involuntary early retirement for health-related reasons, is loss of income.

Income

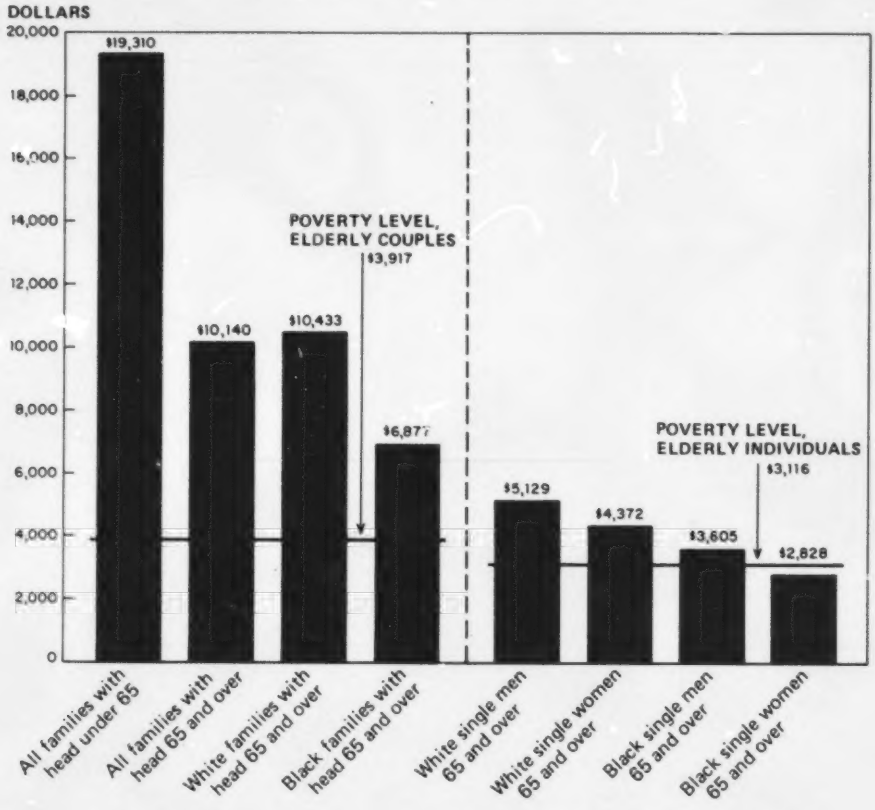
Personal income is usually cut by a third to one-half after age 65 when most people are retired. In 1978 the median income of the 8.5 million families headed by an older person ($10,140) was only 53 percent of the median income of households with a head under 65 years of age ($19,310). The median income of the 7.6 million elderly living alone or with nonrelatives was $4,303 compared with a median of $8,530 for their counterparts under 65. Not all elderly families or individuals are at a financial disadvantage in old age. More than 18 percent of households with a head 65 and over had incomes over $20,000 and 11 percent had incomes exceeding $25,000 in 1978. But at the same time nearly half of families with younger heads had incomes of $20,000 or more and a third had incomes over $25,000.[29]

With the drop in income that comes with retirement, many older persons encounter poverty for the first time in their lives. In 1978, 3.2 million of the elderly, or one in seven (14.3 percent), had incomes below the poverty level of $3,917 for the household of an older couple or $3,116 for an older person living alone or with nonrelatives.[30] Poverty rates were higher for elderly nonmarried individuals than married people (21 versus 8 percent), higher for women than men (17 versus 10 percent), and higher for blacks than whites (34 versus 12 percent). Figure 4, on the next page, shows these differences. Nearly two-fifths (39 percent) of older black women confront the adjustments of old age with incomes below the official poverty threshold.

Adding in the "near poor" sums up the financial status of the elderly more realistically and raises their poverty rate to 23.4 percent (all persons living below 125 percent of the poverty level). In other words, nearly a quarter of today's elderly are officially classified as poor or very close to it. This translates into 5.4 million older Americans with incomes below the official poor-plus-near-poor threshold of $4,896 a year for older couples and $3,895 for older individuals living alone or with nonrelatives. According to Mollie Orshansky, Social Security Administration designer of the poverty level formula, these official figures would be still higher if they included the "hidden poor"—elderly people whose sparse incomes force them to live with younger relatives.[31]

Elderly people's financial status depends a great deal on where their money comes from. Most rely on a mix of sources—Social Security benefits, pensions (both public and private), wages, and income from savings, real estate, or investments. Social Security is by far the most important. Since almost all retired elderly are covered by the system, monthly Social Security checks alone account for nearly four of every ten dollars of money income among older per-

Figure 4. Median Income of Couples and Individuals 65 and Over Compared to Bureau of the Census Poverty Levels and Incomes of Younger Families: 1978



Sources: U.S. Bureau of the Census, *Current Population Reports*, Series P-60, No. 123, "Money Income of Families and Persons in the United States: 1978"; and *Current Population Reports*, Series P-60, No. 124, "Characteristics of the Population Below the Poverty Level" 1978."

sons. Three out of ten elderly depended on Social Security benefits for 90 percent of their money income in 1976. Because such benefits were never intended to provide full financial coverage, those who must rely almost exclusively on them are very likely to have incomes below the poverty level. Elderly persons receiving only Social Security benefits had the lowest median income in 1976 ($3,660) and one-third of these had incomes below the poverty line.[32]

Elderly couples or individuals with employment earnings or income from assets but no Social Security benefits or pensions had the highest median income in 1976—$12,650 and $13,680, respectively. Nearly half of persons aged 65 to 67 reported some job earnings in 1976 but only 14 percent of those 75

and over. This helps explain the higher incomes of elderly married couples (even on a per capita basis) compared to older single persons. People who are still married and living with their spouses after 65 are more likely to be younger and still working than the unmarried in the broad 65-and-over age group. Somewhat over half of the elderly of all ages (56 percent) derive part of their income from assets—savings accounts, bonds, stocks, or real estate. Substantially more whites than blacks and more men than women have asset income available to them in old age.

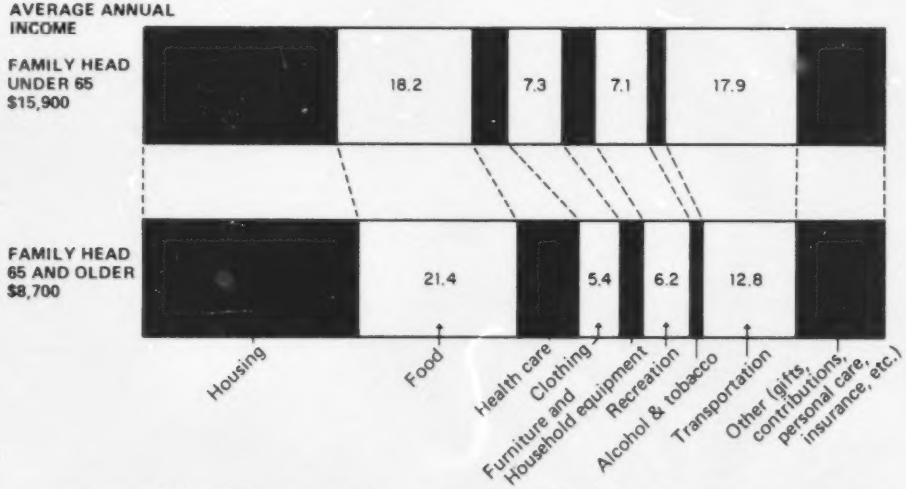
Despite dramatic increases in private pension coverage during the past 30 years, just under a fifth of persons 65 and over had a private pension in 1976, the median value of which was a low $1,870 per year. Only 13 percent of older people received a public pension other than Social Security in 1976, but the median value of this type of pension was about double the annual value of a private pension.

In part to counteract high rates of poverty among the elderly and particularly among those entirely dependent on Social Security, the Supplemental Security Income (SSI) program was instituted in 1974. This guarantees a minimum income for older Americans; however, the maximum payment is a scant $208 a month for an individual and $312 for a couple with no other income. About 11 percent of all those 65 and over now depend in part on public assistance programs, mostly SSI.

Expenditures

Reductions in retirement-age income are not offset by relative decreases in expenditures. Although retirees do not have the transportation or clothing costs of younger, usually better-off, working families, they still must pay for basic necessities. As Figure 5 shows, families headed by an older person spend more of their income than younger families on food, housing, and health care.

Figure 5. Percentage Distribution of Average Expenditures, by Age of Family Head: 1972-1973



Source: Herman B. Brotman, "The Aging of America: A Demographic Profile," in *The Economics of Aging, A National Journal Issues Book* (Washington, D.C.: Government Research Corporation, 1978) p. 38.

Even with Medicare health insurance, older persons still incur large out-of-pocket expenditures for health care. In 1977 these expenses were $1,745 per capita for the elderly, nearly four times the average direct health care costs of those under 65.[33] Since Medicare was enacted in 1966, however, the elderly's out-of-pocket share of their health care has declined from 53 percent to 27 percent. Most of this difference has been absorbed by one or another government health care program.

Soaring inflation has reduced the purchasing power of the large number of older persons who live on fixed incomes. Particularly hard hit have been older persons who rely on savings or on private pensions, most of which do not provide automatic cost-of-living adjustments. Social Security benefits are adjusted for price increases, but even this has not kept pace with inflation. In July 1979, for example, benefits were raised by 9.9 percent, but the inflation rate for the preceding 12 months had been 12.6 percent. Also, these annual adjustments are not retroactive and the elderly do not receive "catch-up" checks to compensate them for their year-long loss in purchasing power.[34]

Among the items hardest hit by the current bout with inflation are food and fuel for heating and cooling. Both affect the quality of life for older persons perhaps more directly than that of younger people. Older people are more susceptible to both cold and heat, for example; the majority of victims during the heat wave of summer 1980 were elderly persons in dwellings without air conditioning. In households where the head is 65 and over, the median expenditure for all home fuels increased from $397 in 1975 to $651 in 1979—a 64 percent increase in just four years.[35]

As data for the 1980s become available, they will likely show that the elderly have shifted even more of their income to necessity items. Inflation has undoubtedly compromised the standard of living for the great majority of older persons.

Housing

"At least 30 percent of the elderly live in substandard, deteriorating or dilapidated housing" declared the U.S. Senate Special Committee on Aging in 1977.[36] But this means that the majority are reasonably well housed, although in smaller, more modest homes than the rest of the population. Nearly three-quarters of the elderly (73 percent) own their homes and the mortgage has been paid off on 80 percent of these properties. However, one in four of these homes was valued under $15,000 in 1976 and one in two elderly-owned units was worth less than $35,000.[37]

Older owner-occupants are considerably more likely to be long-term residents than renters of comparable age. In 1976, one in three of them, compared to less than one in ten renters, had lived in their current residence for 25 years or more. The homes of owners over 65 are also larger, less well insulated, and older than those of elderly renters. This creates maintenance problems for elderly homeowners with limited incomes who may not be able to do their own repairs. Older black homeowners, those with poverty-level incomes, and those living in the South or rural areas are most likely to have houses in need of repair although only 6 percent of all units occupied by elderly owners are recorded as having two or more "deficiencies."[38] In contrast, 15 percent of renters reside in units with two or more structural defects.

Overall the elderly spend only slightly more of their income on housing than younger people—29 percent versus 26 percent in 1972-73 (Figure 5). However, there are about 2.3 million elderly people who have excessive housing burdens. Approximately 30 percent of older renters, 30 percent of older homeowners with mortgages, and 10 percent of elderly homeowners without mort-

gages spend 35 percent or more—or at least a third—of their income for housing. Many homeowners without mortgages keep their housing expenses low by neglecting needed repairs and maintenance.

As we have seen, relatively few people move during their retirement years and, in fact, given the choice, most elderly people, and especially homeowners, prefer to remain for as long as possible in their own homes in the neighborhoods where they have developed comfortable, long-familiar ties. So far, most government housing assistance for the elderly has involved relocating people to newly built apartment buildings and only 3 percent of the elderly benefit from government housing subsidies. Now it is being increasingly realized that programs aimed at helping the elderly to upgrade and maintain their present homes would be cheaper, cover more of those in need of help, and more in line with what the elderly themselves want. If such programs are successful during the 1980s, they should also help to revitalize the deteriorating neighborhoods in the inner cities and small rural towns where so many of the elderly now live.[39]

Marital status, living arrangements, and family help

People's ability to cope with the changes in health and income that come with old age depends a great deal on whether or not they are married, have family members to help out, and their living arrangements. We have already seen, for example, that older married couples are considerably better off financially than unmarried elderly individuals.

Marital status. As shown in Table 9, most older men are married and living with their spouses—78 percent at ages 65 to 74 and 68 percent of those aged 75 and over in 1978. Women at ages 65 to 74, by contrast, are almost as likely to be widowed as married and living with their husbands (41 percent versus 46 percent) and far more likely to be widowed than married at 75 and over (69 compared to 22 percent). This reflects women's greater longevity and the fact that they normally marry men somewhat older than themselves. The average age at widowhood for U.S. women is now 56. In addition, widowed (or divorced) elderly men are apt to remarry because of the availability

Table 9. Marital Status of Population 65 and Over, by Age and Sex: 1978

	Men		Women	
Marital status	65-74	75 and over	65-74	75 and over
Total (in 1,000s)	6,080	3,090	8,189	5,109
Percent	100.0	100.0	100.0	100.0
Never married	5.7	4.8	6.6	5.7
Married, spouse present	78.1	68.2	46.2	21.6
Married, spouse absent	3.0	2.1	2.2	1.3
Separated	2.0	1.2	1.5	0.5
Widowed	9.7	23.0	41.2	69.3
Divorced	3.5	1.8	3.9	2.1

Source: U.S. Bureau of the Census, *Current Population Reports*, Series P-20, No. 336, "Marital Status and Living Arrangements: March, 1978," p. 8.

of single women of their own age group plus the social acceptability of marrying a younger woman. Elderly widowed women, on the other hand, have few potential mates. In 1978 nearly 17 of every 1,000 men aged 65 and older remarried compared to just two of every 1,000 women that age.[40]

Living arrangements. The living arrangements of the elderly are perhaps more varied than those of any other age group. As Table 10 shows, the vast majority live "in the community" and most of these live in family households. Women and the "old old," however, are much more likely than men or the "young old" to be living in something other than the "conventional" nuclear family household of a married couple with or without children and no other relatives. At age 75 and over, women are more than twice as likely as men to be living alone (43 percent versus 18 percent) or living in the household of a relative who is not their spouse (18 percent versus 7 percent).

Contrary to widespread belief, as we have seen, only about 5 percent of all elderly persons and 9 percent of those 75 and over are to be found in institutions at any point in time. These are among the oldest of the elderly population; in 1976 the average age of older persons in long-term care facilities was 81 compared to 73 for the elderly in the community. The institutionalized elderly are also disproportionately white, female, and unmarried.[41]

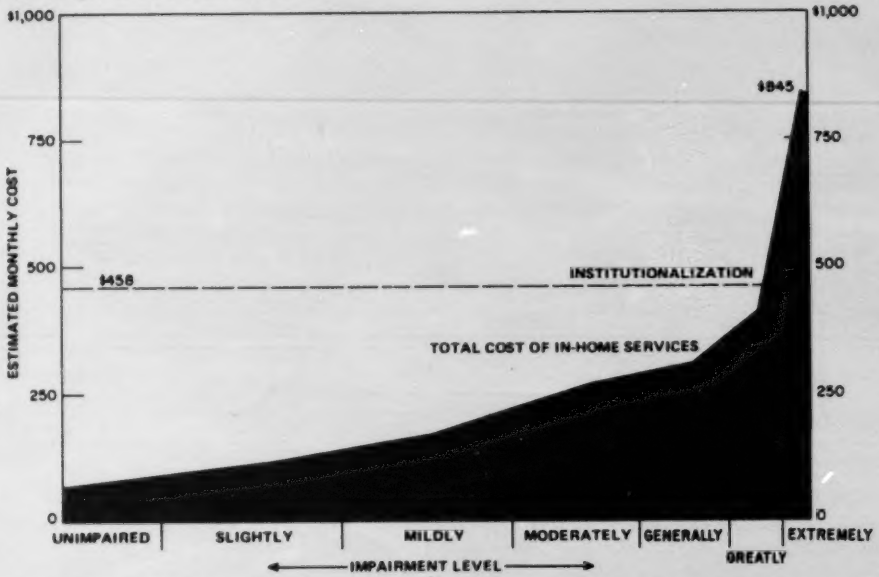
But the main difference between these elderly and others is, as National Institute on Aging Director Robert Butler puts it: "[A large proportion of] people in nursing homes have no families. That's why they're there."[42] Data for 1976 show that well over a third of nursing home residents aged 60 and over need only very little or no help with bathing, eating, dressing, etcetera, and only 14 percent are extremely limited physically.[43] More recent estimates suggest, in fact, that extremely limited older persons in the community outnumber the institutionalized with similar disabilities by two to

Table 10. Living Arrangements of Population 65 and Over, by Age and Sex: 1976

Type of living arrangement	Men		Women	
	65-74	75 and over	65-74	75 and over
Total (in 1,000s)	6,038	3,186	8,898	5,541
Percent	100.0	100.0	100.0	100.0
			In households	
Head of household	95.9	85.5	44.4	51.8
Head of family household	85.1	66.4	8.6	8.0
Head of nonfamily household	0.7	0.7	0.8	0.9
Living alone	12.4	18.4	35.0	42.8
Spouse of household head	—	—	45.7	19.2
Other relative of head	0.7	6.7	7.5	17.7
Nonrelative of head	1.8	1.0	0.9	1.3
			In institutions	
Patient or resident	1.6	6.8	1.5	10.3

Sources: U.S. Bureau of the Census, *Current Population Reports*, Series P-20, No. 306, "Marital Status and Living Arrangements: March 1976," pp. 15, 31, and 33; and tabulations from the 1976 *Survey of Institutionalized Persons* prepared by the Center for Population Research, Georgetown Universtion, for the Administration on Aging, Grant No. 90-17-1681.

Figure 6. Estimated Monthly Costs of Home Services and Institutionalization of People 65 and Over at Varying Levels of Impairment: 1977



Source: Comptroller General of the United States, *Report to the Congress: The Need for a National Policy to Better Provide for the Elderly* (Washington, D.C.: U.S. Government Printing Office, 1977).

one.[44] It is the lack of a spouse, adult child, or other relative to help with routine daily tasks and not medical reasons per se that sends many slightly infirm older persons to nursing homes.

Family help. Survey data demonstrate conclusively that families do not abandon their elderly. For the elderly in good health, frequent visits, letters, or phone calls from adult children are the rule rather than the exception. For the impaired elderly, caregiving by family members is the norm.

Over 80 percent of the home care for older persons is provided by family members and, secondarily, friends.[45] In the vast majority of cases, families look after their elderly without help from community service providers. For policymaking, it is important to note that the value of these family-provided services greatly exceeds the costs of similar services provided by agencies at public expense. Furthermore, for all but the greatly or extremely impaired elderly, it costs less to provide services (by the family plus public providers) at home than in institutions (see Figure 6).

Spouses are the most likely to provide care to the elderly married person who needs physical help. Older couples try to maintain their own intact household as long as possible. This is often accomplished by developing a delicate balance of mutual care and compensation. For the unmarried elderly, the most likely caregiver is an adult daughter. Older persons who are only slightly or even moderately handicapped are likely to stay in their own homes, often alone, and receive help with transportation, meal preparation, shopping, and

cleaning from nearby children. This type of arrangement allows the elderly to maintain the household independence that most older persons now prefer.[46] Only the very old or extremely impaired elderly are likely to share the household of an offspring—usually that of a daughter and her family. Moving in with children is not popular in our society but might become common again, as it was in the past, as the costs of medical care and housing continue to escalate and more and more people survive into advanced old age.

For the adult child who takes an elderly impaired relative into her home, the costs are many. They include not only the financial costs of special diets, rental equipment, and home modification, but also the "opportunity costs" of the outside paid employment, social activities, and privacy which must now be given up. Over 40 percent of adult children participating in one survey of caregiving reported that the time spent on caregiving tasks was at least equivalent to a full-time job.[47] Caregivers also often say they feel isolated, lonely, and restricted, and they usually experience bouts of ambivalence, guilt, anger, disappointment, or frustration.[48] As a last resort, families may seek relief through institutionalization.

The physical and emotional consequences of caregiving are especially severe if the caregiver herself is older. Four-generation families have increased along with life expectancy and, in more and more families, both the caregiver and carereceiver are 60 or 65 years of age and older.

Help for the Elderly

U.S. society's concern with the care and well-being of the elderly has increased steadily in the past 20 years, a trend which partly reflects the sheer growth in the number of older persons and the gradual transfer of some traditional family functions to the public sector. For millions of elderly people, however, daily life is still a struggle with poor housing, social isolation, physical limitations, and low incomes. The following subsections describe the major public and private programs now working to help the elderly. Most of these operate within the "formal support network." The services and programs emanating from the structured and bureaucratic organizations that make up this network are well suited to meeting the routine or highly technical needs of the elderly such as income maintenance and intensive medical care.

But America's elderly are also supported by a less visible but pervasive informal network of families, friends, neighbors, volunteer groups, and church organizations. A recent study of the elderly in Cleveland, Ohio, reveals that it is this network that looks after the bulk of nonroutine assistance tasks.[49] Among the most important are personal care for the frail elderly, help with housing maintenance and transportation, and coordinating and providing information on services and programs available to the elderly.

Today's older people prefer this division of help between the formal and informal support networks.[50] New program initiatives in the 1980s are likely to be directed toward strengthening the informal support network and forging a partnership between the elderly, their families, friends, and communities and the government at every level.

The public sector response

The Older Americans Act (OAA) was enacted in 1965 as the centerpiece of the federal commitment to the elderly. In the absence of a national policy on aging, the objectives of the OAA serve that function. These declare the right of the elderly to:

1. An adequate income.
2. The best possible physical and mental health.
3. Suitable housing.

4. Full restorative services.
5. Opportunity for employment with no age discrimination.
6. Retirement in health, honor and dignity.
7. Pursuit of meaningful activity.
8. Efficient community services.
9. Immediate benefit from proven research knowledge.
10. Freedom, independence, and the free exercise of individual initiative.

The **Administration on Aging** (AoA), within the Department of Health and Human Services (formerly the Department of Health, Education, and Welfare), has major responsibility for carrying out the objectives of the OAA and providing coordination among federal agencies that have programs for older people. AoA does not make cash grants to individuals but is an advocacy agency which channels funds to states, communities, and nonprofit organizations to promote the development and coordination of services for older persons. AoA also sponsors research on the elderly and training in gerontology.

The delivery of services under the Older Americans Act is channeled through the "Aging Network," a system of State and Area Agencies on Aging, which in turn coordinate the delivery of needed services in their communities. When the Comprehensive Older Americans Act Amendments of 1978 are fully implemented, specific funds will be distributed through Title III for social services, senior centers, and nutrition services, Title IV for demonstration projects, Title V for community service employment programs (administered by the Department of Labor), and Title VI for the development of services to older native Americans by Indian tribal organizations. In 1979 Congress also designated OAA funds, for the first time, for long-term care.

The oldest and best known federal programs for the elderly are directed by the **Social Security Administration** (SSA), which is also part of the Department of Health and Human Services (HHS). The 44-year-old SSA provides not only retirement benefits but also disability and Medicare payments. In an average month, some 35 million people, many of whom are elderly, receive some type of Social Security benefit check. Three trust funds finance the system: Old Age and Survivors Insurance, Disability, and Hospital Insurance. SSA also conducts research on issues related to the financial and social implications of retirement.

SSA further directs the **Supplemental Security Income** (SSI) program begun in 1974 to replace state welfare programs for the aged. SSI provides income supplements to qualifying low-income, aged, and disabled persons. Some 2 million persons aged 65 and over—8.3 percent of the elderly population—received SSI payments in 1978.

Title XX was included in the Social Service Amendments of the Social Security Act in 1974. Although a relatively new program, Title XX is heir to a 20-year history of federal cost-sharing programs for the provision of social services, but unlike these earlier programs, it has decentralized the planning and delivery of such services. Within the program's broadly defined guidelines, each state has a great deal of flexibility in tailoring a service package to the unique needs of its residents. As a result, the number and types of Title XX services vary considerably from state to state. Most of those provided to older persons attempt to shore up their ability to function independently.[51] Among the more widely available Title XX services for the elderly are adult day care, homemaker services, and help with chores.

Also operating within the Department of Health and Human Services is the **Health Care Financing Administration** (HCFA). The primary HCFA programs are Medicaid and Medicare—the principal sources of funding for acute and long-term health services for America's elderly. Medicaid reimburses health care costs for low-income individuals of any age; Medicare benefits are reserved for the elderly. Both the Medicaid and

Medicare programs have been criticized lately for emphasizing institutionalization as a long-term care solution at the expense of home-care options.[52]

HCFA also supports research and demonstration projects. Recently HCFA's Office of Research, Demonstration and Statistics has focused on long-term care, particularly the organization, delivery, and costs of alternative types of long-term care.

The **Department of Housing and Urban Development** (HUD) has taken the lead in providing adequate housing for older persons. The agency directs the **Housing Assistance Payments Program** (better known as the "Section 8" program) which attempts to increase the purchasing power of low-income households in the local rental market. Section 8 funds provide direct cash subsidies to landlords and developers. The size of the subsidy is the approximate difference between the rent of a "standard quality unit" and 25 percent of the income of eligible households. Because the Section 8 program permits varying mixes of new, rehabilitated, and existing units, communities have substantial flexibility in responding to local housing market conditions. Half of the participants in the Section 8 program are elderly.

Perhaps the best known of HUD programs is the low-rent public housing program for low-income persons. In 1976, one-third (or 342,000) of the one million occupied units in public housing were occupied by the elderly. HUD supports construction of new units for elderly and handicapped persons through the **Section 202** program and housing rehabilitation through **Section 312.**

Approximately 750,000 older persons benefit from HUD programs, but this accounts for only 3 percent of the elderly. This is mainly because these programs are aimed at renters while nearly three-quarters of the elderly are homeowners. However, HUD is now reviewing new strategies to encourage and assist older homeowners to maintain, modify, or rehabilitate their often neglected homes. Among these are the Neighborhood Housing Services Program, the Experimental Housing Allowance Program, and various Reverse Annuity Mortgage plans.

HHS and HUD are not the only Executive departments administering programs for the elderly. In addition to administering the Senior Community Service Employment Program authorized by Title V of the Older Americans Act, the **Department of Labor** also provides employment services and opportunities to older workers. The **Department of Transportation** is charged with ensuring the access of the disabled (many of whom are elderly) to all forms of transportation. The **Department of Agriculture** administers the food stamp program which many low-income elderly depend on and the donation of surplus food to the Title III nutrition program which provides hot meals five days a week to people over 60.

Operating within the Department of Agriculture, the **Farmers Home Administration** (FmHA) makes low-interest loans available to rural homeowners for maintenance. Elderly people in rural areas may also apply to the FmHA for loans to build, purchase, or rehabilitate appropriate housing.

The **Department of Energy** also supports housing maintenance and repairs. Title IV of the Energy Conservation and Production Act established the weatherization program to encourage insulation of dwelling units occupied by low-income persons, especially low-income elderly. In February 1980, the Senate authorized spending $2.2 billion over the next three years to help low-income families "weatherize" their homes to conserve energy. Funds are provided for installing weather-stripping, storm windows, and ceiling insulation.

The **Veterans Administration** provides retirement pensions to needy veterans of World War II and offers free hospitalization and nursing-home care to any

veteran aged 65 and over, a program that is destined to escalate as the number of elderly veterans triples from about 2.7 million today to over 8 million in 1995.

Within the federal structure a number of other commissions and agencies are directly concerned with the well-being of older citizens. The **Federal Council on the Aging** was created by Congress as part of the 1973 amendments to OAA to advise the Administration and Congress on the special needs of the elderly. The Council serves as a spokesperson for older Americans by making recommendations to the President, to the Secretary of HHS, the Commissioner on Aging, and Congress. Working closely with both the Administration and Congress, it shares with each the results of its public hearings and research. Major issues it has dealt with include discrimination, continuing education, housing for the elderly, and the elderly of minority groups.

The **National Institute on Aging** (NIA) was established as part of the National Institutes of Health by Congress in 1974 through the Research on Aging Act. Under its mandate, NIA has launched programs in biomedical research and clinical medicine, behavioral and social science research, and epidemiology, demography, and biometry (the statistics of aging). In addition, substantial biomedical and behavioral research is conducted at NIA's Gerontology Research Center in Baltimore, Maryland.

The **President's Commission on Pension Policy** was legislated by Congress in 1979 to study the nation's retirement, survivor, and disability policies. Composed of 11 members and chaired by C. Peter McColough, the Commission has conducted an extensive review of retirement programs in both the public and private sectors. Its main task is to recommend ways to ensure that retirement benefits will be adequate to meet the soaring demand that will come when the baby boom generation begins retiring some 35 years from now.

The **Pension Benefit Guaranty Corporation** (PBGC) is also concerned with pensions. Title IV of the Employee Retirement Income Security Act (ERISA) of 1974 established PBGC to provide insurance to participants in retirement programs that are terminated. When a covered plan ends, PBGC guarantees the payment of benefits vested under the terms of the plan within the limits specified in ERISA. This includes payments to surviving beneficiaries under options such as joint and survivor annuities, as well as to the participants when they reach retirement age.

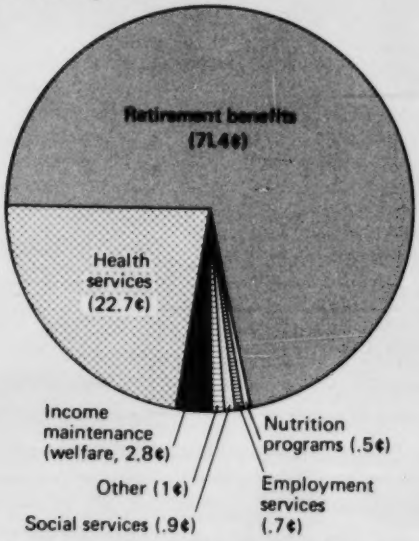
The **U.S. Commission on Civil Rights** has jurisdiction over age discrimination matters. Since 1978 passage of the amended Age Discrimination Act, the Commission has worked closely with Congress and the Department of Health and Human Services in developing government-wide regulations prohibiting age discrimination in employment.

In Congress, the Senate **Special Committee on Aging,** the **Subcommittee on the Aged** of the Senate Committee on Labor and Public Welfare, and the House of Representatives **Select Committee on Aging** initiate special studies, hold hearings, and identify new areas for legislative action. *Developments in Aging*, an annual report of the Senate Special Committee on Aging, summarizes federal department and agency activities in the area of aging.

Evaluating the public sector response

The above review only hints at the extent of the federal involvement in programs benefiting the elderly. The House Select Committee on Aging has identified 48 major federal programs directed specifically at the elderly. If all programs that affect the elderly in some way are included in the inventory, there are at least 135 and perhaps as many as 200 programs at the federal level. They come under the jurisdiction of 49 Con-

Figure 7. Breakdown of the Federal Dollar Spent on the Elderly: 1980



Source: U.S. House of Representatives, Select Committee on Aging, Subcommittee on Human Services, *Future Directions for Aging Policy: A Human Service Model*, Committee Publication No. 96-226 (Washington, D.C.: U.S. Government Printing Office, 1980) Figure 9.

gressional committees and subcommittees and are administered by seven Executive departments and five independent agencies. As Figure 7 shows, most of the federal involvement is in the areas of retirement benefits and health care. Less than one cent out of every federal dollar benefiting the elderly is reserved for social services other than nutrition and employment services.

Clearly there is no shortage of federal programs for the elderly. Nor, on the surface of it, is there a shortage of funds. A quarter of the federal budget in fiscal year 1980, or $155 billion, was allocated to Social Security, pensions, health care, and services for the elderly. As a service delivery system, however, the current federal approach is increasingly under fire, described in Congressional hearings as characterized by "fragmentation, duplication and total lack of coordination."[53] In the area of transportation alone, for example, there are 31 separately funded programs for the elderly which are administered by eight of the 12 Executive departments and independent agencies concerned with the welfare of older persons. Health care and health-related services are provided by an even greater number of programs. Even in communities where all services are available, there is no single source of evaluation and access to this vast, confusing array. Older persons in need of help must struggle through a maze of independent applications for Medicaid, SSI, Title XX, and Title III programs. Often this means trips to several different state and local social service departments scattered all over town. As the system now functions, it is the responsibility of the older individual to determine what kind of services he or she needs, where they are available, and how to orchestrate a comprehensive service package.

This lack of coordination, coupled with limited program funding, helps to explain why many elderly in need go without services. Select Committee on Aging estimates show that only 3 percent of the eligible elderly benefit from community services and only 1 percent participate in the hot meals program sponsored by Title IV of the Older Americans Act. Although 18 percent of the older population were eligible for SSI benefits in 1976, only one in ten received them.[54]

Several demonstration "channeling" projects now under way across the country represent preliminary efforts to solve the problems of coordination and information. The key feature of each is the idea of a single place for an elderly person to go to enter the health and supportive services system. If these projects prove successful, channeling will become a national service standard.

Federal programs and policy on the

elderly can be criticized on another front—their failure to keep up with research in aging. Built into most programs is the perspective of "old-age-as-a-problem." Yet gerontologists are increasingly recognizing that the later part of the life cycle is as much a normal developmental stage as any other, including childhood. Each stage presents a new set of challenges and demands new patterns of adaptation. Old age is no exception. Many of the social "problems" of old age are not innate to the aging process. Rather, areas of concern for many older Americans have their origin in our unique social system and value structure that emphasize youthfulness, age segregation, and independence.

Response from the private sector

Many large-scale, private, often voluntary organizations have also surfaced in recent years to deal with the problems of the steadily growing ranks of the elderly. Straddling the public and private sector are several volunteer programs for and by the elderly administered by **ACTION.** Participants in the Older American Volunteer Program serve as foster grandparents and senior companions. The Retired Senior Volunteer Program provides a variety of volunteer opportunities in which the elderly serve as resources for the improvement of community life. In fiscal year 1979, more than 270,000 volunteers aged 60 and over participated in these programs.

The **National Council on Aging** is an organization established to assist the professional who works with the aging. A nationwide staff of professionals and field workers provides training, guidance, consultation, technical assistance, and publications to local associations and programs. The Council also supports research on the problems of the elderly and attempts to shape public policy. And it maintains the Center for Public Policy which monitors legislation and research relevant to the elderly.

Dating back to 1948, the **Gerontological Society of America** is a national organization for investigators, educators, and professionals whose interests center on basic and applied research on aging and the elderly and on improving the communication of research findings. Its membership includes specialists in biological sciences, clinical medicine, psychological and social sciences, and social researchers and planners. It has now been joined by the **Western Gerontological Society** (a national organization, despite its name) which is oriented more toward practitioners who work directly with the elderly. The **American Geriatrics Society** is the professional organization for physicians with training or interest in geriatric health care. The **International Federation on Aging,** based in Washington, D.C., is a coalition of national organizations that provide services to the elderly or advocate on their behalf. Currently, 51 organizations representing 28 countries participate. The Federation sponsors conferences, develops monographs on select issues, and encourages crosscultural perspectives on aging.

In keeping with the growing recognition of the rights of older persons and coupled with their expanding numbers, several lobbying organizations attempt to mobilize the elderly to press themselves for better low-cost housing, medical care, pensions, and other opportunities for personal satisfaction. The **National Caucus on the Black Aged** and the **National Association of Retired Federal Employees** aim their work at those issues cited as most important by their members. The **National Association for Spanish Speaking Elderly** (Asociacon Nacional Pro Personas Mayores) provides employment opportunities in five states and technical assistance to local organizations and organizes local and national conferences on the Hispanic elderly. The **National Indian Council on Aging** provides similar

services for Indian and Alaskan elderly. The **American Association for Retired Persons** (AARP) was formed out of the National Retired Teachers Association and boasts a membership of over 8 million members aged 55 or over. Services for members in AARP include life, automobile and health insurance, travel planning, educational programs, and informative publications. The **National Council of Senior Citizens** (NCSC), founded in 1961, now has over 3.5 million members. NCSC offers some services similar to those in AARP, but focuses its main thrust on political activism. Its monthly publication analyzes each U.S. Congressperson's and/or state legislator's votes and stand on legislation concerning older people.

One of the newest groups aimed at bolstering the clout of the elderly, and one of the most vocal, is the **Gray Panthers,** founded in 1970 by Maggie Kuhn. The organization's main objective is to develop each member's skills for taking an active role in whatever project he or she considers important. Self-help and consciousness-raising play an important part in the Gray Panthers' activities, although the Gray Panthers speak out on issues benefiting people of all ages.

1981 White House Conference on Aging

A major thrust of current efforts to improve the lot of the U.S. elderly is the forthcoming 1981 White House Conference on Aging culminating in a national meeting in December 1981. This is the fourth federally sponsored conference designed to provide a forum for older Americans to voice their concerns and provide guidance to public and private sector policymakers. A first national conference took place in 1950, followed by White House Conferences on Aging in 1961 and 1971. Some 4,000 delegates attended the 1971 Conference but the 1981 Conference is planned for a smaller gathering of 1,800 delegates.

Coordinating the 1981 Conference takes off from the state level. Since early 1980, community forums have been organized by advocacy organizations and area agencies on aging. Delegates to the conference are being selected at state conferences. The delegates will also participate in local and regional hearings in the summer and fall of 1981 to hear from other older people and discuss the major concerns of older citizens.

Executive Director for the 1981 Conference Jerome Waldie sees one of its major objectives as an expansion of national policy on the elderly to rid it of the stereotype that all older Americans are poor, unemployed, and abandoned by their families. Six broad issues are the focus: Economic Security; Physical and Mental Health; Social Well-Being; Older Americans as a Growing National Resource; Creating an Age-Integrated Society within Social Institutions; and Research. The conference's concluding recommendations will help to define legislation affecting the elderly throughout the 1980s.

Recent legislative changes

Several bills passed during the 1970s focused specifically on improving the economic condition of the elderly. The **Supplementary Security Income Program** (SSI) went into effect in 1974. Aged, blind, and disabled individuals qualify for SSI although the amount of the federal SSI benefit is tied to the recipient's income, living arrangement, and marital status. Individual states are required to supplement the federal benefits to maintain income levels of persons formerly receiving public assistance who were transferred to the SSI program and may elect to raise benefit levels beyond those required. Four out of five SSI recipients in 1978 were age

50 or older and 43 percent were 70 and over. The average monthly benefit to an older person in 1978 was $107 and to an older couple, $147. Most of these elderly receive Social Security benefits in addition to the cost-of-living adjusted SSI payments. SSI payments for 1978 totaled $6.6 billion, with federal payments accounting for three of every four of these dollars.

The **Employee Retirement Income Security Act,** enacted in 1976, allows persons who are not covered by pension plans to deduct up to $15,000 of their annual income for deposit in a nontaxable, individual retirement account (IRA). The **Tax Reform Act** of the same year permits an individual to deposit up to $875 annually in an IRA owned separately by a spouse. This act also allows reduced capital gains taxes for elderly persons who sell their homes and reduced estate taxes for surviving spouses.

Workers 65 to 70 years of age were assured job discrimination protection by the **1978 Amendments to the Age Discrimination in Employment Act** (ADEA). Effective on January 1, 1979, these amendments abolished retirement age regulations for this age group within the federal government, allowed for a jury trial in instances when ADEA suits against private establishments involve monetary damages, and eliminated involuntary retirement in the private sector under seniority systems or employee benefit plans. ADEA's age ceiling of 70 years now covers some 27 million persons or seven out of every ten persons aged 40 to 70 in the civilian labor force. Workers in businesses with fewer than 20 employees are not covered.[55]

In the area of social services for the elderly, perhaps the most important development was passage of the **Comprehensive Older Americans Act Amendments** of 1978. These amendments aim at consolidation of social services, senior centers, and nutrition services into one title—Title III. Although not yet fully implemented, Title III is the first legislative recognition of the problems of coordination that plague this country's delivery of social services. The potential benefits of Title III are limited, however. Coordination with other programs is not specifically mandated. A comprehensive "aging network" continues to be an elusive objective of public policy.

In a poster for the 1981 White House Conference on Aging, senior actress Ruth Gordon helps refute the stereotype that "all older Americans are poor, unemployed, and abandoned by their families."

"Breakthrough" programs and policies for the elderly were notably absent from the catalog of legislative developments during the 1970s.[56] While federal government efforts expanded in previously defined areas of concern, specifically income maintenance and health care, recent legislation has not dealt with other areas which should be fundamental to policy on the aging.

Initiatives for Change: Challenges of an Aging Society

As its population ages, the United States faces social and economic problems that are common to all aging countries, particularly the financing of public pensions and provision of adequate long-term care. The problems do not stem solely from the sheer increase in either the absolute or relative numbers of older persons. The numbers pose problems only because over the last few decades the public sector has assumed increasing responsibility for the care and well-being of its older citizens.

With the commitment to income maintenance, health care, and social services for older persons, the federal budget is "graying."[57] Expenditures for the elderly totaled $112 billion, or 5 percent of the gross national product, in fiscal year 1978 and rose to $155 billion, a quarter of the federal budget, in FY1980. Retirement benefits paid to those who contributed to Social Security during their working years and their dependents account for the largest share. Health care, and particularly long-term care, is the second area where expenditures are large and escalating rapidly. Public programs, principally Medicare and Medicaid, paid $27.7 billion or 67 percent of the total personal health care costs of the elderly in FY1977. Medicare payments alone increased from $18.3 billion in that year to approximately $26.4 billion two years later and are projected to reach $44.5 billion by 1983, according to the Office of Management and Budget.

The graying of the federal budget may undermine the special status which the elderly have long enjoyed. Demographic trends superimposed on existing program commitments guarantee that public expenditures for the aged will escalate. With increasing calls for tax cuts and a balanced budget, new or expanded benefits will face tougher opposition than in the past. They will also face competition from other minority groups. Although current public support for the elderly is hardly adequate, the elderly nonetheless have fared better than other groups in securing housing assistance, tax advantages, and health benefits. And policy analyst Robert Hudson observes that "this growing sense of relative deprivation on the part of other groups" is putting competitive pressure on the "discretionary" federal budget.[58]

Despite large expenditures, it is becoming increasingly clear that current federal approaches and funding levels are insufficient to meet the needs of today's elderly. As noted, for example, the Older Americans Act Title VII nutrition program is currently meeting only 1 percent of the national need. Robert Binstock, former president of the Gerontological Society of America, asks: "Are we looking toward an appropriation of over $20 billion that would be required to fund an adequate number of nutrition programs throughout the country? And tens of billions for each of the other programmatic needs?"[59] It also appears unlikely that expenditures will keep up sufficiently with inflation and the mounting numbers of older persons to maintain, much less expand, existing program benefits.

Whose responsibility?

The challenges of an aging society in the 1980s and beyond clearly demand changes in current approaches. Income maintenance and health care strategies are being reexamined critically in light of the fundamental questions: Who should do what, when, for whom, and how?[60] Proposed solutions tend to emphasize targeting benefits selectively at those with the greatest need. There is also renewed interest in sharing responsibility for the elderly between public and private resources. The thrust

of policy in the 1980s may well be to formalize the existing, but usually uneasy and overlooked, partnership between all levels of government, the elderly themselves and their families, and private agencies, church groups, and neighborhood associations. To understand the origins and potential structure of such a coalition, we need to examine two policy areas: financing the Social Security system and health care coverage.

Financing Social Security

The Social Security system of 1980 bears faint resemblance to the program enacted in 1935. In the middle of the Depression, the program was established specifically to *supplement* individual savings for retirement from contributions by employees and employers. It was designed as a pay-as-you-go system, with the contributions of current workers financing the benefits of the retired. Payroll deductions began in 1937 when they amounted to a 1 percent tax on earned income up to $3,000 for a maximum employee contribution of $30 a year.[61] By 1967 the maximum deduction had risen only to $174. In 1977, however, Congress mandated eight increases for the years ahead. The fourth of those increases, in 1980, hiked the Social Security tax rate from 6.13 percent to 6.65 percent for a combined employer-employee rate of 13.3 percent. Simultaneously the taxable wage base increased from $25,900 to $29,700. By 1990 the combined employer-employee share will climb to 15.3 percent and the taxable base will be adjusted to the average national wage increase. If one assumes a real wage increase of 1.5 percent annually throughout the 1980s, workers with high incomes will be contributing $5,300 annually (in 1981 dollars) to the Social Security system in 1990.[62]

ACTION photo by Linda Bartlett

A retiree works in ACTION's volunteer Foster Grandparents Program.

Changes in coverage and scope account for part of the system's increased revenue needs over the past 45 years. Until the 1960s, only a small number of older persons qualified for retirement benefits. People qualified by stages as they worked, contributed to the system, and became eligible on retirement. Coverage of different occupations was staggered as well, with physicians being the last large group to join in 1965. Today, nine out of ten workers are covered by Social Security, although federal workers are still exempt and employees of state and local governments are not required to participate.

In 1956 the system was expanded to include disability benefits; Medicare was added in 1965 and the Supplementary Security Income (SSI) program in 1974. Social Security benefits for the retired and their dependents are financed from the Old Age and Survivors (O.A.S.I.) trust fund. As programs were added, so too were trust funds—one for disability and one for hospital insurance. SSI payments are made out of the general revenue fund.

The trust funds vary in financial health. The O.A.S.I., which is in the

most immediate trouble, is expected to develop cash-flow problems in the early 1980s, due to slower economic growth, inflation (which automatically triggers benefit increases), increases in life expectancy, and increases in the number of Americans who are retiring early and taking reduced benefits at age 62. Because the elderly are spending more years in retirement, they are collecting benefits longer, and because of cost-of-living adjustments, their benefits are larger. In the year 2000, a man of 69 and a woman 72.5 years old will have the same life expectancy as a 65-year-old had when the Social Security Act was passed in 1935.[63] One demographer has estimated that, on average, a man claiming reduced benefits at age 62 increases his retirement time by 22 percent and may collect slightly more in benefits altogether than if he waited until eligible for full benefits at the "normal" retirement age of 65.[64] A shift of just one year in the average length of retirement raises or lowers the Social Security deficit by nearly $350 billion.[65]

The Social Security Advisory Council has repeatedly assured working and retired Americans that benefits will not stop or be reduced and has made several recommendations to Congress for dealing with the system's short-run problems. Among key proposals are financing from general revenue funds, borrowing between funds, removing disincentives to working (currently, elderly persons receiving retirement benefits forfeit $1 for every $2 they earn above the $5,000 limit), and taxing the benefits of the small proportion of elderly whose income exceeds the tax-exempt level. Congress has been slow to act on proposals from the Advisory Council in the past, however, and for the immediate future the only adjustments will be the increases in the tax rate and maximum taxable income mandated in 1977.

In the long run, the Social Security system faces a different kind of challenge. After 2010 the baby boom children of the late 1940s and 1950s will begin turning 65. But the explosion of people who will then be claiming retirement benefits is only one side of the problem. Because fertility dropped off dramatically in the 1960s and is now below replacement level, the ratio of elderly persons to those in the working ages will go up sharply. As shown in Table II, if fertility rises slightly to 2.1 children per women and stays there (the Census Bureau's "most likely" projection), the number of people aged 65 and over for every 100 persons aged 18 to 64 will increase from 18 in 1980 to 26 in 2020 and nearly 32 in 2030. And this "aged dependency ratio" presents only the optimistic picture. Not all people aged 18 to 64 are in the labor force; many young people will continue postponing entry into the labor force until their mid-20s and, if current retirement trends continue, sizeable numbers of those aged 60 to 64 will be retired.

In 1980 three workers pay benefits for one retiree. If there are no changes in the present pay-as-you-go system, two workers will be required to support one retired person after 2010 and the combined employer-employee Social Security tax rate could climb to somewhere between 25.4 and 45.3 percent in 2030. Those who cite such alarming projections foresee a bitter conflict between the working generation and the retired generation as the inevitable result. But it is unlikely that the current funding system will be maintained. Further, considering the alternatives to Social Security—stranding the elderly without retirement incomes or absorbing the financial support of their own parents—few working-age Americans advocate abandoning the system entirely.

The *total* dependency ratio (the number of people under 18 plus those 65 and over for every 100 aged 18-64) shows little change until at least 2020 (Table II). Some have interpreted this to mean that increased expenditures for the elderly will be offset by lower

Table 11. Projected Total Dependency Ratio, Aged Dependency Ratio, and Young Dependency Ratio: 1980-2030

Type	Number of persons per 100 aged 18-64					
	1980	1990	2000	2010	2020	2030
Total dependency ratio (under 18 and 65 and over)	64.3	63.5	63.2	59.4	67.2	73.8
Aged dependency ratio (65 and over)	18.4	20.0	19.9	20.2	26.0	31.8
Young dependency ratio (under 18)	45.8	43.5	43.2	39.2	41.2	42.0

Source: U.S. Bureau of the Census, *Current Population Reports*, Series P-25, No. 704, "Projections of the Population of the United States: 1977-2050."

Note: Based on Series II projections of the Census Bureau which assume small declines in death rates, constant net immigration of 400,000 annually, and 2.1 children per woman—a mid-range increase over the current total fertility rate of approximately 1.8. The Census Bureau considers this set of assumptions "most likely."

public costs for educating and maintaining the young. However, economists Robert Clark and Joseph Spengler estimate that the per capita public cost of the elderly is about three times what it is for young people under 18.[66]

To deal with these long-run demands on the Social Security system, other proposals are being considered. It appears likely that major incentives will be developed to encourage people to stay in the labor force beyond 62 or 65, or the eligible age for receiving even reduced benefits may be raised even beyond 65. Although Social Security benefits are already retrogressive (that is, low-wage earners receive back relatively more in benefits than high-wage earners), the low-to-high benefit ratio may be widened to concentrate more income support on those with low lifetime earnings. There may also be renewed emphasis on the original concept of Social Security as a supplement to retirement income rather than the sole source that it now is for many. The U.S. today has one of the lowest savings rates of developed Western countries. Stimulating workers to build up a retirement nest egg of savings and assets may be a major policy focus during the remaining two decades of the century.

Discriminating against older women

Financing benefits is not the only problem confronting the Social Security retirement program. Pressures are mounting to eliminate provisions that discriminate against older women. Divorce, remarriage, and women's labor force participation have all increased dramatically since Social Security was enacted. But the system still reflects the assumption that women marry once and do not work outside the home. Women who deviate from the pattern are penalized.

A woman who divorces before accumulating ten years of married life loses any claim on either a wife's or a widow's retirement benefit. Married women who work, on the other hand, receive no returns on their contributions to Social Security. On retirement, a married working woman is entitled to either her own benefits or half of her spouse's, whichever is greater. Because benefits are linked to length of work life and lifetime earnings, a 50 percent share in the husband's basic benefit is usually the larger of the two. As a result, most women receive nothing in return for their contribution via the payroll tax deduction system.

Proposals are now pending to eliminate both of these inequities. In the near future, it is likely that the duration-of-marriage requirement will be eliminated or at least reduced from ten to five years. Since the 50 percent bonus for lifetime housewives is not likely to be repealed by a politically sensitive Congress, rectifying the treatment of working wives will be expensive and may be delayed as a result. But with the majority of women now working, some change in the current system seems inevitable.

Health care and the elderly

Health care policy in this country has two often contradictory objectives: quality care and cost containment. Neither is being met by current programs for the elderly, primarily because of the mismatch between these programs and the elderly's health care needs.

Although most elderly people have one or more chronic illnesses, the vast majority can still function well until after 75. The 75-and-over age group, appropriately termed the "long-term-care population,"[67] differs from younger people in that their health care needs are generally for sustained, nontechnical, and usually nonmedical care rather than the highly technical medical services needed by the acutely ill.

Both Medicare and Medicaid are oriented to the medical model of health care delivery. They are effective in reducing the elderly's medical bills for hospitalization, surgery and recovery, and drugs. But long-term care benefits under either program are mostly restricted to the chronic-care medical services provided by nursing homes. Medicare pays for supportive or home care of the elderly only when this is a follow-up to hospitalization and only for those who also require skilled nursing or rehabilitation for the same condition that prompted hospitalization, and coverage is limited to 100 days. Medicaid covers home care services only if ordered by a physician and only if the provider is deemed qualified and is not a relative. The search for such a "qualified" home health care provider is often fruitless as the demand greatly exceeds the supply. Because of these restrictions, many elderly people are forced to enter a nursing home if they are to secure reimbursed long-term care. Estimates of the number of elderly inappropriately institutionalized range from a low of 16 percent to a high of 35 percent.

Nursing home costs consumed nearly 41 cents of each Medicaid dollar in fiscal year 1978 although only 6 percent of Medicaid recipients were in nursing homes.[68] Just 1 percent of total Medicaid expenditures in that year went to home-based, long-term-care services.

Although Medicare is health care insurance coverage for the elderly of any income, this was the primary source of payment for only 2 percent of people in nursing homes in 1977 while Medicaid was the primary source for 48 percent. This anomaly results from restrictive Medicare regulations. The program reimburses institutionalization only for elderly persons with "rehabilitative potential" and those with specific diagnoses, and only after a hospital stay of at least three days. Coverage is further limited to 100 days in a skilled nursing facility and only the first 20 days are paid in full. More flexibly, Medicaid covers the costs of both "intermediate care" and skilled nursing facilities. Because of different income standards, Medicaid nursing home coverage is often available to people whose incomes would not be low enough to qualify them for reimbursed home care. In other cases, individuals run out of money quickly in a nursing home and become eligible for Medicaid assistance after they are admitted.

Claude Pepper, chair of the House of Representatives Select Committee on the Aging, sums it up: "It is easier for an older person to get into a nursing

Photo by Harold M. Lambert

home than to be cared for at home."[69] This unnecessary institutionalization is costly for both the federal budget and older people and their families. And the costs are not just financial. Most older persons would prefer to remain at home and receive supportive services there. The elderly who do not require the totally dependent and structured environment of an institution often deteriorate quickly both physically and mentally in a nursing home. Families who would like to look after older impaired relatives themselves are often frustrated by the lack of home health care support services.

The high cost and limited effectiveness of current long-term-care provisions in Medicare and Medicaid are prompting a detailed investigation by researchers and policymakers alike. Most are coming to the conclusion that without the involvement of "natural" support systems—mainly the family—the public sector cannot meet the health care needs of today's elderly, let alone those of tomorrow's elderly population which will include many more of the 75-and-over elderly who require most long-term care. The new program strategy now being considered faces the difficult task of shoring up the informal support network without strangling it in bureaucracy that will undermine its flexibility and effectiveness. Among the most frequently proposed options are cash reimbursements to family caregivers, tax deductions for caregiving to the elderly, and development of geriatric day care centers and "respite care" services. A key feature in shifting away from excessive public financing of institutionalization toward community care is the idea of "channeling." Most agree that comprehensive assessment and evaluation procedures and community coordination of services and providers are prerequisites for improvement.

Aging in International Perspective

In the long run, the aging of populations in countries around the world is inevitable. Only two other demographic alternatives exist: unending population increase (high fertility and moderate to low mortality) or population extinction (mortality exceeding fertility).[70] The U.S. and other developed countries already have "old" populations and the proportions of elderly persons are likely to increase still further. In developing countries, however, the population age structure is young and will remain so into the foreseeable future.

The populations of less developed countries are still growing at the very rapid rate of about 2 percent a year.[71] Although women in many developing countries are beginning to average fewer children each than their mothers did, the large numbers of young people in the childbearing ages means annual numbers of births continue to increase, thus broadening the base of the population age structure. This is reinforced by recent reductions in mortality which have been concentrated in the younger age groups. The median age of the

Table 12. Percent of Population 65 and Over, World and More and Less Developed Regions: 1960, 1980, 2000

Region	Percent of population aged 65 and over		
	1960	1980	2000
World	5.2	5.8	6.3
More developed regions	8.5	11.4	13.2
North America	9.1	11.0	12.1
Europe	9.7	13.0	14.3
Oceania[a]	7.4	7.9	8.9
U.S.S.R.	6.8	10.0	12.0
Less developed regions	3.7	3.9	4.6
Africa	3.0	3.0	3.3
Latin America	3.5	4.1	4.6
East Asia[b]	4.8	5.9	7.8
South Asia	3.2	3.0	3.7

Source: United Nations, Population Division, *World Population and Its Age-Sex Composition by Country, 1950-2000, Demographic Estimates and Projections as Assessed in 1978*, ESA/P/WP.65 (New York: 1980).

[a]Includes less developed countries of Fiji, Papua-New Guinea, Western Samoa, Solomon Islands, and other Pacific islands.

[b]Includes Japan which is more developed.

population in developing regions is less than 22 years and nearly four in every ten persons is under 15 years of age.

In sharp contrast, developed countries as a whole have birth rates half the average rate of developing countries (16 compared to 32 per 1,000 population) and only slightly lower death rates (9 versus 12 per 1,000 population). While the populations of developing countries are growing at rates that, if sustained, will double their numbers in just over 30 years on the average, many developed nations are approaching zero population growth. Average life expectancy also differs sharply—from 72 years in developed countries to 15 years less (57) in developing countries. As a result, the concentration of persons aged 65 and over is much greater in developed regions—11.4 percent compared to 3.9 percent in less developed regions in 1980, as shown in Table 12.

Although the proportion of elderly in less developed countries is comparatively low and will remain low to the end of the century, these countries contain a large absolute number of elderly. By the year 2000, the total number of persons aged 65 and over in the world is projected to exceed 396 million, with 229 million, or 58 percent, in the developing countries. Whereas the number of elderly in the developed countries is likely to increase by 58 percent, the number in the developing countries will almost double.[72]

Care of the elderly in developed countries

The developed countries share a bureaucratic approach to providing for the elderly. All have some type of public retirement benefit system, although public spending on the elderly varies from 21 percent of the gross national product in Austria to 6 percent in Japan and 5 percent in the U.S. Income maintenance programs in developed countries do not erase lifelong income differences among their older citizens. Most have some type of supplementary security income program which augments pension benefits for the needy. Developed countries also usually provide health care benefits for their elderly

and specialized health care services. The U.S., however, lags far behind in the training of geriatricians and provision of specialized geriatric hospitals or wards.

Although social services for the elderly are universal in developed countries, the emphasis and organization of services vary widely. Western European countries tend to favor supportive services in providing long-term care and many have highly innovative approaches.[73] In Sweden, for example, rural postmen monitor the elderly on their routes and are equipped to provide temporary help and report back to a district coordinating service agency. In all developed countries, however, the family still provides most of the care for the impaired elderly.

Social and economic problems still persist despite these far-ranging programs. Except in Japan where multigenerational family living is still common, many of the elderly in urbanized, industrialized countries end up living and interacting mainly with others of their own age, cut off from meaningful social roles and activities.

Care in developing countries

National programs for the elderly are limited in less developed countries and the family is the main provider of all support. In developing countries that do have old-age pension systems, coverage is usually limited to the relatively few people who were salaried workers for industry or government during their productive years. Organized social services are rare. In some countries, private charities are active in caring for the elderly, but most developing countries are attempting to build on natural support networks.[74] A prime example is China where trained nurse practitioners work in many villages and train others in basic care of older people.

Reliance on informal support networks creates special problems for the developing countries. Because they still expect to depend mainly on adult children in old age, many younger adults are reluctant to accept family planning services. In turn, continuing rapid population growth and consequent demands on limited national resources severely inhibit governments' capacity to finance programs for the elderly. In recognition of these and other problems of the aged unique to developing countries, the United Nations has called for a World Assembly on Aging in 1982. The Assembly will focus on the role the elderly can play in the development of their countries and will encourage active participation of the elderly in its discussions. Developing countries will be encouraged to learn from the failures as well as the successes of program strategies in developed countries. The U.S. Secretariat for the Assembly is also requested to expand its activities on behalf of the elderly by promoting seminars, workshops, and special studies on strengthening the family's resources for care of older persons.

Regardless of the policies adopted in developing countries, it is clear that their growing number of older persons will initiate social changes. In this respect, they will not differ markedly from the United States or other developed countries. □

World Bank photo by G. Franchini

An old man in Alfonso Caso, Mexico.

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